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School of Nursing
University of Ottawa

the Canadian Nurse

School of Nursing
University of Ottawa

VOLUME 56 • NUMBER 1
MONTREAL
JANUARY 1960

Sincere Wishes
for a
Happy
and
Prosperous
New Year

OWNED AND PUBLISHED BY
THE CANADIAN NURSES' ASSOCIATION


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THE CANADIAN NURSE

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Volume 56

JANUARY – DECEMBER

1960

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THE CANADIAN NURSE

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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
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Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

Volume 56! It does not seem possible that it is almost five years since the golden anniversary of the founding of our *Journal* was celebrated. Month by month we are edging closer to the 60th — the diamond anniversary of publication. How should that be celebrated?

* * *

Elsewhere in this issue is the half page application form that we invite you to use to secure your own copy of the index of the material published in 1959. The copies will be available within the next few weeks.

Even though the *Journal* is published in separate issues for each of our national languages, both are combined insofar as the index is concerned. Every article that has been published in either language during 1959 is included in this bilingual reference.

Since only a limited number of copies of the index is printed, please send your application form along immediately.

* * *

An important announcement, appearing on page 74, heralds the second step in the program of translation from one language to the other that began with the first issue of *L'Infirmière Canadienne* in June, 1959. Beginning next month *all* of the professional advertisements will be published in both languages — those giving information regarding postgraduate courses in universities and hospitals as well as the numerous institutions and organizations that are seeking staff for a variety of positions.

Some of you may wonder why the *Journal* Board considered it just and right to share all of the information regarding employment or postgraduate training opportunities in obviously English language institutions with our French-speaking colleagues. The answer puts those of us who are English-speaking only to shame! Thousands of the nurses whose native language is French are completely or partially bilingual. Many of the latter long for the chance to improve their knowledge of English through association with completely English-speaking staffs and patients. How many of us whose native tongue is English would have the courage to seek work in a French hospital?

* * *

A shining example of complete bilinguality is our gracious president, Miss ALICE GIRARD, whose New Year message appears in this issue. Despite an exceedingly heavy work-load as director of nursing at Hôpital Saint-Luc, Montreal, and principal of the school of nursing there, Miss Girard finds time and energy to shuttle back and forth to Ottawa for frequent meetings, to meet with government committees, to perform all the multifarious duties that fall to the lot of the president of an organization as busy as the Canadian Nurses' Association. We were very hesitant about adding to her tasks by our reminder of the guest editorial. We are most happy that she consented to send us all her message.

* * *

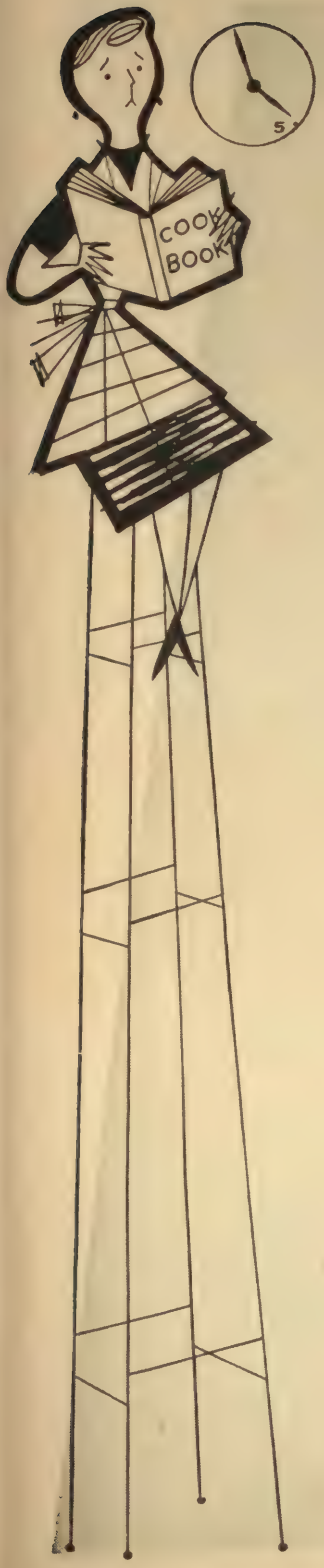
All of us have been subjected to the objective-type examinations at one time or another. "Parlor games," those who consider them much less effective than the essay-type examinations, will snort. If you feel that way about them turn to the sample questions in DR. W. H. LUCOW's article and, without referring to the correct answers, complete the test to the best of your ability. You *may* be due for a surprise!

* * *

Thousands of new patients are admitted to hospitals all over our country every day. For some it is an awesome experience, a step into the unknown that is beset with fear, even terror. Even where prepaid hospitalization plans relieve anxiety regarding expenses, there may be a haunting dread of rapidly accumulating bills for extras that will whittle away careful savings. Above all, there are all those questions that have to be answered for the person in the admitting office!

The thoughtful, kindly nurse in that department of the hospital, who welcomes the new patient with as much courtesy and friendliness as a good hostess welcomes a guest in an up-to-date hotel, can help to soothe the fears and calm the doubts, even though she is swamped by a heavy list of new admissions. As is pointed out in our brief series of articles on the work of the admitting department, that is where good public relations begin.

Without music life would be a mistake.
— NIETZSCHE



THIS little housewife had a problem — sweet-tooth Hubby on a sweet-free diet. (And beginning to get nervous about it.) She tried everything. Fancy salads. Bigger helpings. But Hubby's frown darkened by the day. Then one day she read in a magazine about a discovery, a new non-caloric sweetener. One that she could actually cook and bake with — in any food, at any temperature. One which gave the perfect taste of sugar — with no bitter aftertaste in ordinary use. That night there were cookies, pudding, coffee — *sweet* coffee — and a big, big smile across the table . . .

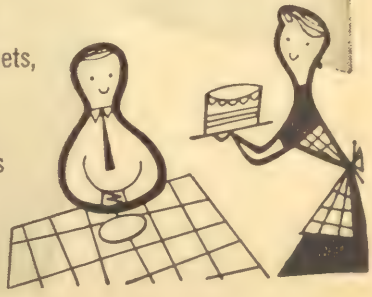


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Administration—Average adult dose is a 250 mg. tablet q.i.d. with meals and at bedtime.

Description—Altafur, brand of furaltadone, is a nitrofuran (synthetic antimicrobial, not an antibiotic or sulfonamide). Chemically it is 5-morpholinomethyl-3-(5 nitrofurfurylideneamino)-2-oxazolidinone.

Manufacturer—Eaton Laboratories, Norwich, N.Y. Canadian distributors: Austin Laboratories, 32 Baker St., Guelph, Ontario.

CATRON

Indications—Anti-depressive agent effective in mental illness, angina, and hypertension.

Administration—Must be given by mouth.

Description—One of a group of agents known as monamine oxadase inhibitors which operate by inhibiting enzymes in the body that destroy neurohormones such as serotonin and norepinephrine.

Manufacturer—Lakeside Laboratories (Canada) Ltd., 24 Wellington St. West, Toronto, Ontario.

DESITIN HC

Indications—To alleviate inflammatory and allergic symptoms and to promote healing in severe, acute and chronic inflammatory internal hemorrhoids (non-surgical), proctitis, cryptitis; inflamed postoperative scar tissue; internal anal pruritis.

Administration—1 suppository twice daily for up to six days or as required.

Description—Each suppository contains 10 mg. hydrocortisone, high grade Norwegian cod-liver oil, lanolin, zinc oxide, bismuth subgallate, balsam of peru, in a cocoa butter base.

Manufacturer—Desitin Chemical Company, Providence R.I., Canadian Distributor: Leslie A. Robb, 54 Baby Point Rd., Toronto, 9.

DIAPARENE PERIANAL CREME

Indications—For prevention and treatment of stool irritation (perianal dermatitis) in the newborn.

Description—Active ingredients are methylbenzethonium chloride, zinc oxide, starch, cod liver oil and casein in a water repellant base.

Manufacturer—Homemakers' Products (Canada) Limited, 36 Caledonia Rd., Toronto, 10.

HEATEX

Indications—To aid in the prevention of heat fatigue and exhaustion.

Description—Each tablet combines: sea salt containing the 39 analyzable trace elements that are lost in human perspiration, ascorbic acid and dextrose.

Manufacturer—Taylor Laboratories, Houston, Texas.

HISPRIL

Indications—Wide variety of allergic conditions and non-allergic upper respiratory infections.

Administration—Available in 5 mg. spansules and 2 mg. scored tablets. Adults: 1 spansule every 12 hours or 1 tablet 3 or 4 times daily. Children: under 6 years, ½ tablet (1 mg.) once or twice daily; 6-12 years, adult dose or 1 spansule daily or a 2 mg. tablet b.i.d.

Description—Hispril contains diphenylpyraline hydrochloride.

Manufacturer—Smith Kline & French Laboratories, Montreal 9.

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Description—Mephyton is Vitamin K, (2-methyl-3phytyl-1, 4-naphthoquinone).

Manufacturer—Merck Sharp & Dohme, Division of Merck and Co. Limited Montreal, 30.

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Manufacturer—White Laboratories Ltd., 5100 Sax Street, Montreal.

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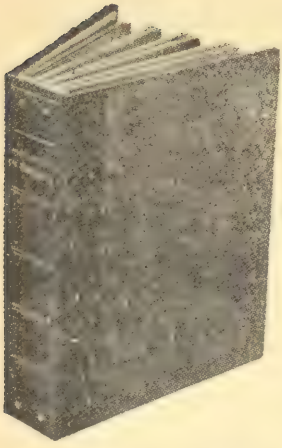
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Manufacturer—Clay-Adams Inc., 141 East 25th Street, New York 10.

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Manufacturer—Baxter Laboratories of Canada, Ltd., Alliston, Ontario.

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Random Comments

Dear Editor:

May I say that I do not agree completely with the author of "Why Judge Them?" of the November issue. The author lays the total blame at the doorstep of the parents. This conclusion is based on the testimony of the unmarried mother. How valid then is this conclusion? It is unlikely that a young woman in this position is capable of examining herself or her parents objectively, either before or after becoming pregnant.

The author mentions the number of broken homes and unhappy homes that are not actually physically broken. If this is a reason, why are there not more unmarried mothers among the daughters of these homes? Surely there are more unhappy homes than there are unmarried mothers.

Is it not more correct to find some explanation in the fact that the unmarried mother is unable to cope with the experiences of her life in a way which is acceptable to the mores of society. Surely the therapy used in the author's homes for unmarried mothers verifies this latter point of view.

D. R., Saskatchewan

Dear Editor:

I have just read my November copy of *The Canadian Nurse* and I would like to comment in particular on the article about the unmarried mother.

The subject has been dealt with most compassionately and very understandingly. It should be required reading for parents with teenage daughters or sons! Over and over again psychologists have pointed out how necessary firm but just parental control is in the lives of children. Our girls and boys need to know where their parents stand in relation to certain moral issues so that they, too, can take a stand. The example set by the parents, the opportunity for frank discussion between mother and daughter, father and son — all help our young people in their very important business of growing up to mature happy adulthood and, eventually, parenthood.

I am called upon to do considerable student nurse counselling in my work. I most certainly intend to use this article in my discussions with the girls since I feel that it will contribute to their understanding of others and also help them personally.

E. M. H., British Columbia

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Dear Editor:

I am finding the issues of *L'Infirmière Canadienne* very interesting but I would like to see more articles related to otolaryngology and ophthalmology.

Having had a friend who had surgery performed for a detached retina, I would like to know more about this condition — its causes, the operative technique and prognosis.

L. F., Quebec

Dear Editor:

May I use this opportunity to tell you how much I appreciate *L'Infirmière Canadienne.*

It helps me to keep up with the new techniques and new drugs that appear almost daily and with which I am unfamiliar.

M-B. P., Quebec

Dear Editor:

I did not have to turn over the page to know the author of "Great Expectations," though I did so with interest to finish reading it.

May I congratulate you on a very excellent article? A few more like it should work marvels in this day and age, when this aspect of nursing appears to be among the last to be given consideration.

M. M., Quebec

Dear Editor:

I want to congratulate you on *L'Infirmière Canadienne,* which is a very instructive and interesting journal. It provides hours of profitable reading and keeps one up-to-date with the latest medical discoveries and new techniques in the various hospital departments.

Enclosed is a money order for a year's subscription and I shall certainly renew it at the end of that time. Thank you for the special rate for student nurses.

R. F., Quebec

Did you know that men such as Einstein, Max Born and Sikorsky were all refugees, who gave their adopted countries priceless knowledge and industry?

The Red Cross World, Vol. XXXIX, No. 3

The best mirror is an old friend.

— George Herbert

* * *

Love your neighbour, yet pull not down your hedge. — George Herbert

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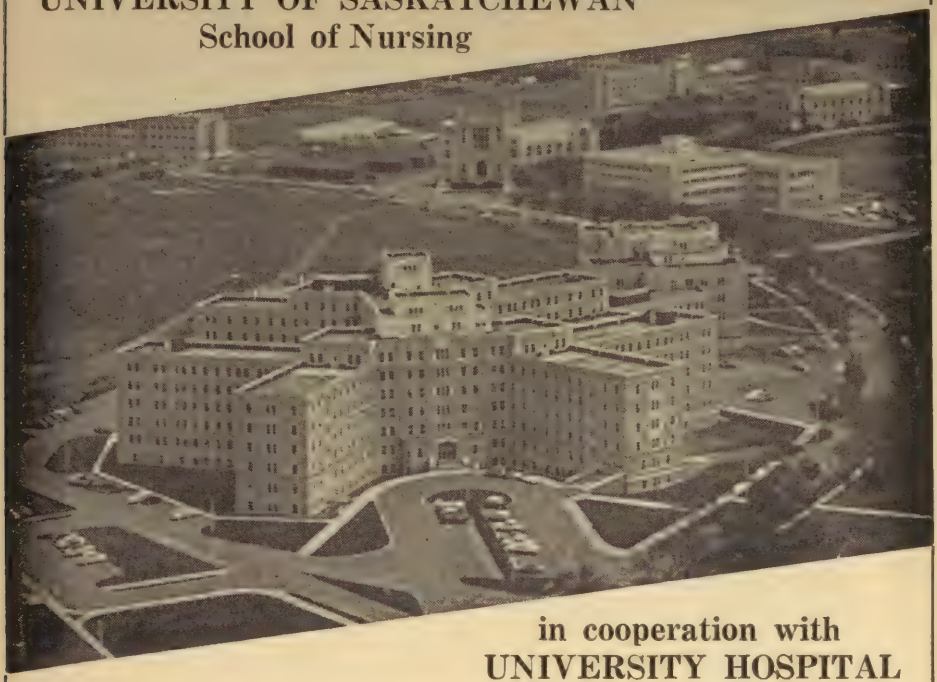
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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 1

MONTREAL, JANUARY 1960

Wanted: Leaders

With the increasing development of a social consciousness in the varied and complex problems of the nursing profession today it seems that a major concern must be the development of leaders. On a board scale, we are concerned with the changing policies and philosophy of nursing education and nursing service. We want our schools of nursing to be organized, administered and financed in such a way as to conform with modern theories of education. We want our nursing services geared to the fulfilment of the needs of society. We are anxious to determine most efficiently the functions of our various categories of professional nurses and of our nursing personnel. We wish to make clear what we expect from nursing studies and research projects and how we plan for the maximum utilization of the data we collect. When we examine these problems from all these angles, we are perhaps partly justified in thinking that what we need most may not be more nurses but more leaders.

On a smaller scale. we are confronted with the everyday problems of leadership. We must select and prepare the nurses who, through the experiences and skills that they acquire as teachers, head nurses and supervisors, will prepare for the broader tasks that today's changing order will present as tomorrow's challenge.

We often hear the complaint that



(G. Carpenter)

ALICE GIRARD

potential leaders are loath to accept positions of leadership. Have we made these positions appealing enough to induce those who show some promise of success, to want to accept the added responsibilities? Should we not start looking for potential leaders among student nurses and is it not our duty to train leaders? We never know the measure to which a person can develop leadership qualities until she has been given the opportunity to exercise this ability. We all know persons who have developed surprisingly well when placed in the right situations. Since leadership is concerned with how people can be helped to work together effectively and happily towards a common end, team work offers good situations for the young nurse to try her skills in human relationships. Studies made by the Carnegie Foundation indicate that success in leadership depends more on desirable personal qualities than on any other single factor.

The young nurse with these qualities in such a situation can often, with youth's natural vigor, energy and enthusiasm, gain what she lacks in experience, for experience is of value only if it has been of the right kind. If the young nurse offers possibilities that we must not neglect, the mature nurse on the other hand may have the surer judgment, the breadth of vision and the prestige that her accomplishments offer. She is also more apt to have better developed skills, ability and poise. Have we not all, at one time or another in our career, admired a mature leader who has influenced our behavior and inspired our life? In a study of why some leaders fail, the leading reasons were lack of appreciation of the importance of human relations, inability to cooperate with others, to delegate responsibilities and to make decisions.

Mildred E. Newton states five "I" qualities designed to help attract and develop potential leaders:

Identify the leadership characteristics.
Interpret the role of a leader.
Inspire the ambition to become a leader.
Instruct for leadership.
Initiate the climate for leadership.

To elaborate on these qualities would take too long. All are, perhaps, equally important but I believe that the last one should permeate all phases of the others. Before complaining of the lack of leaders let us look at the air that we create around us and see if it is that of a good climate in which to grow leaders.

Newton, M. E. Developing Leadership Potential. *Nursing Outlook,* July 1957.

ALICE GIRARD
President
Canadian Nurses' Association

Going to Boston in February?

The annual four-day joint sectional meeting of the American College of Surgeons will be held at the Sheraton-Plaza Hotel, Boston from February 29 through March 3. Nurses are guests of the college and as such pay no registration fee.

The preliminary program is as follows:

February 29

Morning: Panel — The Person with an Ileostomy

Afternoon: Panel discussion and demonstration — Surgical Sepsis.

March 1

Morning: Panel — Rehabilitation of the Severely Injured Patient.

Afternoon: Panel — Medical and Surgical Nursing in the Basic Curriculum.

March 2

Morning: The Burned Child: fresh burns, the convalescent patient, nursing aspects.

Afternoon: Panel — Nursing Research: Its potential Growth and Development

March 3

Morning: Panel — Comprehensive Care of Patients who have Maxillofacial Surgery and Laryngectomy.

There will be hospital tours and demonstrations for nurses Monday through Wednesday.

Three Wishes

Dorothy M. Percy

Remember if you can the message given to you on your graduation day. How different perhaps from these three wishes for a group of 1959 graduates.

In the far off olden time (1926) when I was briefly associated with The Ottawa Civic, it seemed a busy enough place in all conscience. The first of the new houses in this area were creeping close to the hospital. There was, however, considerable concern lest patients' relatives and friends would find the hospital "a bit far out" on visiting days.

Now, in more senses than one, the Civic is almost in centre town. As this hospital, built in the 1920's, strives with courage, energy and vision to meet the medical and nursing needs—and demands — of the 1950's, we see an increasingly meaningful interchange between hospital and community. For example, nurses in hospital are finding themselves giving more health teaching to patients and their families. This is part of the therapy in which the nurse in hospital participates.

Conversely, the nurses in the community are doing more bedside nursing as greater numbers of patients move out earlier from hospital to their homes. This movement is bound to be accelerated. Early ambulation, self-help, rehabilitation — all of these and other factors as well are adding to clinical nursing the coloring of that which was once considered public health nursing only. The care in their own homes of increasing numbers of patients discharged earlier from hospital or prevented from going unnecessarily into hospital, is giving clinical coloring to the work of the public health nurse.

This is interesting and challenging for the hospital and the community. Among other things, it points up the interdependence of the two and the urgent need for the development and maintenance of close and better communication between them. There are important implications, too, for the education of the student nurse.

It would be fatally easy for me at this point to elaborate on the complex and baffling problems that face nursing today. Some of the problems you are familiar with; others will doubtless affect you shortly. Today is supposed to be, in a very special sense, *your Day*. For you, then, I make three wishes. I wish for you:

1. *A hard life*
2. *The courage to be "different."*
3. *Something which, for the moment, will be labelled simply "J.A."*

Now what do I mean by deliberately wishing you "a hard life?" Am I completely out of step on an occasion when, as a matter of course, the most frequently repeated wishes you will hear will be for you success and happiness? Not at all. These things are not mutually exclusive — success, happiness and hardness of life. I believe, with all my heart, that young people have a tremendous capacity for response to the present-day equivalent of "blood, sweat, toil and tears." The trouble is, that we so often offer them instead of bread, a "stone."

I repeat therefore the hope that you will have a "hard life." Please note, I am not suggesting that there should be any slackening in efforts to bring about long overdue improvements in nurses' salaries and working conditions. Such improvement is vitally urgent. What I *am* pleading for is that as young nurses you will not think exclusively in terms of *security* but rather of *how* and *where* you can make the best investment of your newly acquired professional skills, not only as nurses, but also as citizens.

Mr. Gratton O'Leary, speaking some time ago to the Rotary Club of Ottawa, characterized as frightening this

pitiful craving for the unadventured

This address was given to the 1959 graduating class of the Ottawa Civic Hospital by Miss Percy, Chief Nursing Consultant of the Department of National Health and Welfare, Ottawa, Ontario.

> life, for what is called "security:" men at 20 dreaming of 65; in youth, aspiring to a safe senility; men becoming smaller and meaner through shrinking from the duties and responsibilities of life.

In my travels across Canada in the course of my work I see nursing in many of its aspects. I catch glimpses of the needs and the breath-taking challenges there are for young people in our country. Never were the opportunities so many or so exciting for the young nurse who is alert, keen and ready to meet them head on. Don't let anyone tell you the pioneer days of Canada are over! There are still frontiers — even in the geographical sense.

The horizons are indeed unlimited. One thinks of the opportunities presented by the newer concepts of nursing care in the fields of psychiatry, rehabilitation, geriatrics, home care, etc. There is the crying need for more well-prepared teachers in schools of nursing. The changing emphases in community nursing are fascinating, too. Nursing has struck its tents and is on the march.

Nor are the opportunities limited to our own country. Canadian nurses are making a distinguished contribution in many centres abroad through the World Health Organization and Colombo Plan programs.

The word *apprenticeship* is not in very good odor in nursing education circles today. We might remind ourselves, however, that in medieval times a person was apprenticed not to a *job*, but to a *master*. Frankly, I look forward to the day when we shall have "Masters of Nursing" (not necessarily or solely in the academic sense, increasingly important and desirable as these degrees may be for a certain number of nurses) but *masters of the art of nursing;* practitioners *par excellence* of nursing in its widest and deepest sense, from whom the on-coming generations of nurses can learn much that is not contained in textbooks. Perhaps one or two of you may, after the "passport" you receive today has been stamped with various experience "visas", aspire to be that kind of practitioner of nursing. It could be rewarding not only for you, but for your patients and the doctors as well.

So much for the "hard life" that is going to make demands on everything you have to offer of skills, personality and character. What about my second wish — the courage to be different?

One of our greatest dangers today, not only in nursing but in almost every field, is that of developing into "conformists." People are afraid to be "different," of being "individuals." This is particularly tragic when we see it among young people who should be, in the constructive sense of the word, rebels. Quoting Mr. O'Leary again:

> We think in headlines, live on slogans and catch-words dreamed up for us by cocksure commentators on radio and television who have all life's answers wrapped up for us in cellophane. We are all "know-how," and no "know-why"; all facts and no knowledge, all specialization and no wisdom; all signposts and no destination.

Rather grim, isn't it? But there is a hard core of stern truth in it. It *is* hard to be an individual today, to think independently, to act independently. We move with the herd. We are vulnerable to the impact of mass communication media. "Togetherness" has become a cult. It is increasingly difficult to obtain time, quiet and privacy in which to learn "the color of one's soul."

I should like to incite you to open rebellion against the *status quo*. The problems that beset our profession need some fresh, independent thinking. Don't sit back and let the "nursing leaders" do this for you. Believe me, *they* are groping, too? Yours may be the ideas that will help cut through some of the tired clichés and inadequate compromise solutions. In whatever field of nursing you find yourself, don't be afraid to think as an individual, and to make your views known. It may be hard to be different but it is essential if we are to break out of this vicious circle of mediocrity and conformity. "Where all think alike, no one is thinking very much."

Now I suppose you are wondering about my third point — *"J.A."* There is a little old book in my bookcase of which I am very fond. Its title is "Pedagogue Pie." It was published in England in 1936 (now out of print, alas!) and was written by D. F. P.

Hiley, then about to retire after 40 years as headmistress in a girls' school.

The author must have been a salty old lady and although her terse, pithy, philosophical reflections have to do with teachers and teaching, much of what she has to say applies equally well to nurses and nursing. For instance, she makes this strong plea for the development of interests outside one's work:

> Though one should give one's whole self to one's profession it is just the superabundance of personality that will not be absorbed, but slops over into other things that is going to make one's work vital and productive.

This seems to me an important word for our day when we are all in every walk of life, caught in traps of over-organization and over-specialization. Do make sure, as you launch out into your professional life, that you invest in those values that, strictly speaking, lie outside nursing but which, in a very special sense, will increase your stature as a nurse.

I would wish for you that you never lose your desire to learn something new (or, it may be, something old); that you keep your sense of curiosity sharp; that, if you think you haven't had much time up to now to read widely, you will set about discovering the delights and consolations of books.

Nurses, you know, (at least we older ones) are sometimes suspected of being narrow in our interests and, it must be confessed with sorrow, even of being a bit tedious, earnest and downright dull! Anything that will jolt you out of your nice comfortable rut, that will broaden your horizons, will help make it unlikely that you will ever be labelled "dull."

I think here, too, of music, painting, bowling, dramatics, swimming, square dancing, gardening, cycling, bird watching, hobbies of various sorts; work with church groups, community activities — oh, just dozens of things. The main thing is that whatever you do should be different, in degree at least, from your everyday work. Most important, it should be something *you* like doing because it's fun, not because you (or anyone else) thinks you should do it.

You see, outside interests will help to make you a more vital, more interesting, more understanding person: in short, a better nurse, well equipped to give generously of yourself to a troubled world hungry for friendly concern. Hear our retired headmistress again:

> What really permanently impresses one is the increasing richness of life . . . Do let the free part of your personality flap in the wind. Keep your sense of wonder fresh and your interests active, especially human, artistic, spiritual interests.

Oh yes, what is *"J.A."?* This is an abbreviation I use to designate something that the headmistress feels no professional woman should be without — a touch of what she calls "joyous assishness" — the art of being, every once in a while, and for no particular reason, just what it says — "a joyous ass"!

How about a "spot of J.A." — guaranteed to have definite value as a head shrinker, and as an allround, sure-fire antidote for the "poison" of taking oneself or one's work too seriously? Just a mite crazy, you understand. As the headmistress puts it: "There is something to be said for an agreable touch of lunacy. Madness is so vitalizing." Not a bad prescription, taken in small doses with a nice discrimination, whenever you find yourself becoming tense, irritated and frustrated with this exasperating business of being a nurse.

Now one last word which, I think, sums it all up and apart from which nothing we are or do has any real or lasting significance. Dr. Karl Menninger, one of the world's outstanding figures in the mental health field says: "Love is the key to the successful treatment of the mentally ill patient." He might have said: "Love is the key to the successful treatment of *any patient,* or indeed of any person." This we must learn for it says it all.

It would seem of utmost importance that all of us understand that, when we say this, we are expressing our belief in something that is more than a pious platitude, totally unrelated to the stark requirements of professional competence. In the heartbreaking pressures exerted today on hospitals there is a real danger of the personal factor being overlooked in pursuit of organization. Faced by the need for ever-

expanding facilities and mounting costs, it is inevitable and understandable that hospital authorities be ceaselessly concerned with efficient operation. We need to remind ourselves from time to time of the reason for the existence of a hospital — that the services rendered are *for a person.* given *to a person, by a person.* This philosophy must permeate the attitudes and behavior of all who serve in the health field. It will affect especially the one who has the closest relationship to the patient, the nurse.

You who are graduating are well equipped for what you have to do. You have much to offer your patients in the way of skills and techniques. It is vital for the safety, comfort and ultimate recovery of your patients that you understand the purpose and nature of these and that you perform them well. But you and I know that, while essential, these are not the whole of nursing. In spite of scientific discoveries and technical advances in medicine (rather, perhaps, because of them) your patients, who are human, are still very much in need of understanding, sympathy, and compassion.

Many patients, I think you will find, are impressed not so much by what you *do* for them or *with* them, but by what you are *to* them. It is what you give of yourself that is of therapeutic value. So, in this "helping" profession you have chosen — this "giving" profession, if you will — make sure that in addition to everything else you give your patients, you give them yourself, too. As one of the older poets reminds us, "The gift without the giver is bare."

This final thought I want to leave with you has been well said recently. I quote from an editorial written in tribute to the late Dr. William Cone, of the Montreal Neurological Institute.

> To all those who came to him wondering and worrying, he gave the fullness of his hope, and in the hopeless times, stood with them in their sorrow.

In the Good Old Days

(The Canadian Nurse — JANUARY, 1920)

Possibilities of Newfoundland — Lord Morris said, not long ago, that there are sufficient fish on the Newfoundland banks and along the Newfoundland and Labrador shores to feed the whole of the British Empire. It is the second largest producer of iron in the British Empire, England being first. There is enough to supply the needs of the world for the next hundred years.

* * *

The Mothers' Memorial — A silver cross, hung from a purple ribbon, is to be given to any mother in Canada who lost a son in the war. Major-General Mewburn, Minister of Militia, is the authority for the statement.

* * *

The Prince a Canadian — In one of his after-dinner speeches in New York, the Prince of Wales said: "I have become a rancher and a farmer in a small way by buying a ranch in Alberta. This makes me feel quite a Westerner; for the young, free, democratic spirit of the West appeals to me enormously. I had a wonderful time in Canada, and Canadians quite spoiled me by the kindness and hospitality which they showed me throughout my three months' tour across the Dominion and back." In another speech he said that he came to the United States not only as an Englishman, but as a Canadian, across a border for three thousand miles undefended by a fort.

* * *

Belated News for Eskimos — The Eskimos living near Cumberland Bay, on the Arctic Coast, had had no visitors from the outside world since 1917. When the crew of a Norwegian steamer told them of the end of the war, and the Allied victory, they were greatly excited. They celebrated with singing and dancing, to the music of a melodeon. They were strongly pro-Ally, as they had been badly treated by a German crew that visited them before the war. They were skeptical about the submarines, being unable to understand how a vessel could sink another vessel when itself under water.

It is true that liberty is precious — so precious that it must be rationed. — LENIN

Test Construction in Nursing Education

WILLIAM H. LUCOW, PH.D.

If you have had difficulty in measuring the achievements of your nursing students and can identify your problems, the solutions may reveal themselves in this study of the construction and use of objective tests.

PRESENTED below are the ingredients of a four-session course in test construction given to teachers from Manitoba schools of nursing at their Institute for Instructors held June 15-19, 1959 in Winnipeg.

Session One started with the instructor's declaration that the invitation "tickled him to death" like the grasshopper who swallowed a caterpillar.

The purpose of the gathering was to gain facility in constructing and using objective tests with which to measure the achievement of nursing students. The virtues of objective tests, validity and reliability, were briefly discussed, and the meeting went on to the practical consideration of a sample test based on one of their offerings, *Fundamentals of Nursing*. As an introduction, the test was taken by the teachers themselves, who were then in a better position to follow the argument on how validity and reliability might be incorporated. The test is given in full on page .

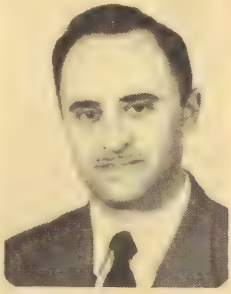
The first step in test construction is the drawing up of a *table of specifications*. This should be done before the first lecture is given. The syllabus or program of studies together with the textbook are studied by the instructor, who then draws up a plan of topics weighted in importance by percentages. The proportions of marks for each topic in the final examination correspond roughly to those planned. The table of specifications, used as the basis for the sample test in the fundamentals of nursing appears on page .

Each topic in the table of specifications is identified by a key letter, to be used on 3 x 5 cards when the individual items are composed. This should be done daily, after each lecture, so that the final test may have content and curricular validity. By the end of the course the file of items should be large enough to afford an adequate selection.

Validity may be further incorporated by dropping or altering items that prove ineffective in the first administration.

Session Two was used to analyze hypothetical answers to the test. (The instructor did not use the responses by the teachers in the audience because he felt sure all items were answered correctly, and there would be nothing to analyze.) Mimeographed copies of the hypothetical answer sheets were distributed, and all teachers present could proceed individually with the tabulation and analysis of scores. The Tabulation Sheet is shown on page 32. An "x" indicates a correct response, and an "o" indicates an incorrect response.

Analysis of the items was directed toward two aspects of validity: the index of difficulty and the index of discrimination. The difficulty of an item is defined as the percentage of correct responses. Thus, a high index of 90% indicates an easy item, while a low index indicates a difficult one. Items correctly answered by all can-



WM. H. LUCOW

Dr. Lucow is in the Faculty of Education, University of Manitoba.

didates must be eliminated. Similarly, items missed by all should be thrown out. A good working range is from difficulty indexes of 30% to 70%, with more of them closer to 50% than far from it. Items 6, 27, 28, and 13 would obviously be thrown out on this score.

The index of discrimination indicates whether the top students did better on an item than did the bottom students. In order to determine this index, the pupils are listed in order of merit, as on the tabulation sheet, and the top half is compared with the bottom half (or top third with bottom third). Item 14, on which more poor students did better than the good students, is an example of reverse discrimination. Such an item should be dropped when the test is revised.

The details of test construction and analysis of results may be found in most of the references listed at the end of this article.

Session Three was concerned with elementary statistical notions of measures of central tendency and dispersion of marks. This led to a discussion of the normal curve and the awarding of marks on the basis of standard scores rather than on raw scores.

Session Four continued the matter of marks and grades with consideration of a special problem that had arisen in practice.

Suppose an instructor of nursing students realized the unreliability of raw scores and proceeded to give letter grades, A, B, C, D, and E in the course. For final record purposes, however, the marks must be stated in numbers out of 100. The problem was: *How might letter grades be converted into number scores?*

These conditions had to be met in solving the problem:

1. The pass mark was 60, so an "E" would have to be below 60.

2. The distribution of scores would be assumed to be normal.

3. The grade "C" would extend half a standard deviation on either side of the mean, and the other letter grades would be one standard deviation wide proceeding from "C" as in the diagram below.

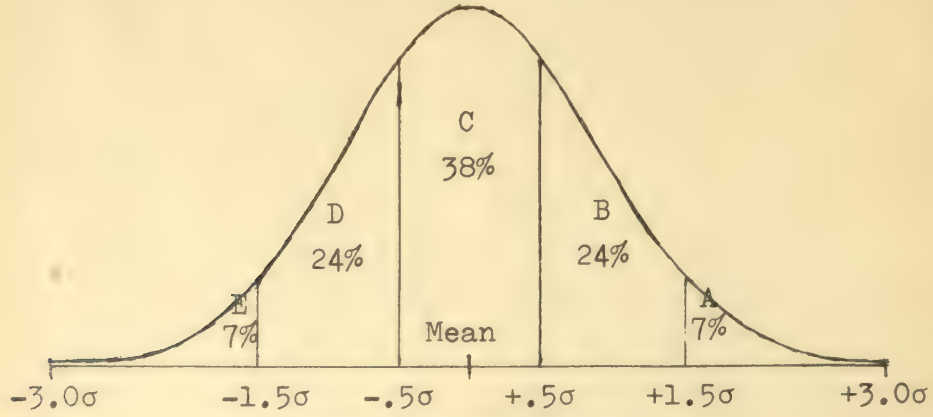
4. The mark of 100 would be at the position three standard deviations from the mean.

The following formula was derived to fulfill the foregoing conditions:

$$L = \frac{80}{9} \quad \frac{X-M}{\sigma} \quad \pm \frac{220}{3}$$

where L is a standard score satisfying the conditions, X is the numerical raw score of a candidate, M is the mean of the group writing the examination, and σ is the standard deviation of the group.

The information in this formula could be used to solve the original problem of converting letter grades into numerical scores. Using the boundaries set by the conditions above,



THE NORMAL CURVE

A five-letter marking system would have the indicated percentage of students getting each grade.

the practical limits turn out to be:

A = 87 to 100
B = 78 to 86
C = 70 to 77
D = 60 to 69
E = below 60

Some subjective judgments would have to be made in deciding whether a mark was a high A, a middle A, or a low A, etc.

The last session ended with a discussion of essay-type questions and how they might be made more reliable.

Table of Specifications

Fundamentals of Nursing

(Based on Harmer and Henderson, *Textbook of the Principles and Practice of Nursing,* Fifth Edition, Macmillan, 1955)

	TOPIC	*KEY LETTER*	*PER CENT*
I.	*Place of Nursing in Health Service*	P	5%
	1. Purpose 2. Relationships (with others concerned) 3. Functions 4. Preparation		
II.	*Ministration of Nursing Care*	NC	30%
	1. Nurse uses her ministration as a means of knowing the patient as a person. 2. Through her ministrations, the nurse attempts to meet the physical, psychological and spiritual needs of the patient in order of relative importance to him. 3. During the ministrations, the nurse: Encourages the patient to care for himself by such means as: placement of articles, special equipment convenience of arrangement, written directions. Helps the patient to accept care necessarily given by others and to seek help when appropriate. Uses her ministrations for teaching those facts and procedures, purposes and rational of his therapy which the patient can use in meeting and solving problems of rehabilitative self-care. 4. Nurse uses the ministrations to seek evidence that the necessary modifications in the activities of daily living, such as: eating, resting, exercising, eliminating, are directed toward rehabilitation. 5. When patient's concerns of a medical nature occur or persist, the nurse encourages him to discuss them with the physician, or, if he is unable to, the nurse herself seeks medical resources for him.		
III.	*Observation*	O	20%
	1. Nurse notes patient's characteristic physical, intellectual, emotional and social behavior to situations such as: placid, tense, compliant, aggressive, withdrawn, out-going, optimistic, pessimistic, euphoric, inconsistent, garrulous, quiet, social reasoning, opinionated, sad, happy, constructive, negativistic, thoughtful, gullible; alarmist, realistic, breadth of interests, attention span. 2. Nurse notes patient's response to stress, such as: anxiety, hostility, aggression, withdrawal, over-alertness, over-talkativeness, perspiration, tremor, flushing, ill-at-ease.		

3. Nurse notes patient's individual responses to therapeutic measures in their relationship to his characteristic behavior.
4. Nurse notes the relationship of the patient's behavior in the activities of daily living, such as: self-regulated exercises, sleep habits, food habits, rest habits; to the health teaching he receives from the nurse, and to his expressed attitudes toward life.

IV. *Teaching* T 25%

1. In planning health teaching with the patient the nurse seeks verbal expression of the patient's concept of his condition and its management, as well as an expression of his readiness and motivation to learn self-care.
2. Whenever possible, the nurse includes members of the patient's home setting in her teaching of home care.
3. Before presenting information, the nurse seeks evidence of the patient's ability to carry out self-care, or of his knowledge of what changes in his condition to watch for, such as signs of progress or of regression; or of his ability to observe and to use his ability to observe, and to use his reactions to therapy as a means of regulating his care with safety. She then corrects misinterpretations, presents additional information, and reinterprets with him.
4. Nurse seeks evidence that her teaching has increased the patient's awareness of his health problems, his capacity, and limitations, to the point that the patient understands what follow-up is desirable and where to seek it.
5. Nurse permits the patient to make his own decisions, or collaborates with him when they share in making plans which affect him. Nurse helps the patient to solve his problems by encouraging him to express the first steps that he sees toward a solution and reviews these with him before adding factors or suggesting alternatives for his consideration. When patients with similar clinical conditions discuss the problems they have in common, the nurse guides the group in solving problems of self-care.

V. *Communication* C 20%

1. Nurse in authority has some direct communication with the patient and is obtainable if he requests her.
2. Nurse gives evidence, through statements and gestures, of consistent acceptance of the patient, without approval or disapproval.
3. Nurse permits the patient to set the direction of discussion about himself. For the most part, the nurse keeps the conversations patient-centered. Nurse identifies and keeps the concerns expressed by the patient in focus as long as he discusses them. Nurse identifies and seeks to clarify with the patient what meaning his illness has for him, such as: pain, fear, mutilation, recurrence, recovery, death; his relationships, such as: family, friends, doctor; and his life settings, such as: home, work, social, spiritual.
4. Nurse clarifies the patient's questions with him and tests his meaning of the terms he uses before answering him. Nurse tests the

patient's understanding of the terms she uses and the explanation she gives him.

5. When patient's concerns of a medical, spiritual or emotional nature recur or persist, the nurse encourages him to discuss them with the appropriate person of authority, or, if he is unable to, the nurse herself seeks the appropriate authority for him.
6. Nurse reflects the patient's feelings without any interpretation of them. In reassuring the patient, the nurse isolates or seeks to to have the patient express the hopeful facts that he sees and reviews these with him before adding other hopeful truths.

An Objective Test on Fundamentals of Nursing
Experimental Edition

(Based on Harmer and Henderson, *Textbook of the Principles and Practice of Nursing,* Fifth Edition, Macmillan, 1955)

Section One

Instructions: Use *T* for *true* and *F* for *false* in answering the following statements.

Record your answers on the answer slip provided. Do *not* write on this paper.

Example: Disease is an abnormal state of the body. T

Etiology refers to the treatment of disease. F

1. Likes and dislikes of food by the patient must be ignored while he is in hospital.
2. A nurse must be impersonal when referring to a patient: she should say, "the cardiac in Bed 2" rather than the name of the patient.
3. Deep-seated emotional stress may interfere with the appetite of the patient.
4. Occupation and economic status of the patient must not affect the kind of care given by the nurse.
5. It is appropriate and desirable under some circumstances to do things for patients that they are entirely able to do for themselves.
6. In pediatric service, a dose of T.L.C. may be given without a doctor's prescription.
7. Constipation is more crucial than kidney failure.
8. Play therapy has a meaning for the nurse that is different from its meaning for the psychologist.
9. The most difficult phase of medical practice is diagnosis.
10. The introvert is often elated and euphoric.

Section Two

Instructions: Complete the following statements on your answer slip.

Example: The capital of Manitoba is ..... Winnipeg

11. Normal body temperature on the centigrade scale is .....
12. Meat should not be served on Friday to a patient whose religion is .....
13. The collection of all information about a patient is known as .....
14. A state of unconsciousness from which the patient cannot be aroused is reported as .....
15. Inactive exercise in the form of massage is referred to as .....
16. Symptoms that cannot objectively be observed by the nurse, such as pain or itching, are classed as .....
17. Activity with no serious motive or material gain is known as .....
18. Conversation and interest of the nurse is, for the patient, a psychological .....

19. Assistance to a mother during and following delivery is one of the phases of nursing referred to as .....

20. A psychotic who alternates between extremes of moods is classed as .....

Section Three

Instructions: Put the letter representing the best answer on your answer slip.

Example: The nurse's greatest responsibility is toward

(a) doctor
(b) patient
(c) hospital
(d) supervisor

answer: (b)

21. Restoration of patient to optimum independence is referred to as
(a) rehabilitation
(b) recuperation
(c) revival
(d) a miracle

22. The gynic shape is
(a) fat
(b) feminine
(c) tonic
(d) tall

23. The "seven danger signals of cancer" taught by the Canadian Cancer Society includes
(a) discharge from your job
(b) persistent hoarseness or cough
(c) any change in a sore
(d) persistent constipation or difficulty in elimination

24. In the matter of elimination, the nurse is responsible for
(a) diagnosis of stool
(b) treatment of metabolism
(c) analysis of urine
(d) facilities and privacy

25. The ultimate aim of psychotherapy is
(a) shock treatment to precede lobotomy
(b) mental deficiency
(c) to bring about self-treatment
(d) to bring the person into satisfactory relationships with others

26. The best guide in selecting occupation and recreation for an individual is
(a) mental age
(b) chronological age
(c) height
(d) weight

27. Rehabilitation begins with

(a) diagnosis

(b) treatment

(c) psychosis

(d) remuneration

28. Probably the most effective method of teaching a patient to look after himself is by

(a) lecture and presentation

(b) supervision and demonstration

(c) example and discussion

(d) written instructions

29. An exuberant, optimistic, talkative person might be described as

(a) hypoactive

(b) hypodermic

(c) hyperactive

(d) hyperglycemic

30. The main purpose of a nurse

(a) is to cooperate with doctors

(b) remains unchanged throughout history

(c) is to achieve a healthy citizenry

(d) is to make the patient feel he can depend on her

Section Four

Instructions: Write the letter before the words in Column B that best match the words in Column A. Write only on your answer slip.

Example:	*Column A*	*Column B*	*Answers*
	1. nurse	(a) chemical	
	2. patient	(b) teacher	
		(c) pupil	1. (b)
		(d) emotion	2. (c)

Now do the following:

Column A	*Column B*
31. nystagmus	(a) twitches and tics
32. aphasia	(b) difficult breathing
33. fabrication	(c) abnormal eye movements
34. photophobia	(d) fear of photographers
35. cyanosis	(e) inadequate oxygenation of blood
	(f) hatred for cameras
	(g) whispering
	(h) flight of ideas
	(i) needle-work
	(j) lying
	(k) inability to arrange words

(l) abnormal sense of smell
(m) occupational therapy
(n) sensitiveness to moderate light
(o) temporary suspension of breathing

Now do the following:

36. No substitute for this in actual nursing
37. Estimate of patient's needs is based on this
38. An example of a misleading symptom
39. Exclusively the doctor's responsibility
40. Symptoms may be exaggerated by this

(a) hunger
(b) intelligence
(c) cough
(d) hypodermic
(e) interest in medicine
(f) shyness
(g) experience
(h) speed
(i) patient's request
(j) observation
(k) printed chart
(l) hypothesis
(m) patient's imagination
(n) prognosis
(o) treatment

Section Five

Instructions: In this section you must choose all the correct alternatives and omit all the incorrect ones. There may be one, two, three, or all four correct.

Tell the whole truth and nothing but the truth.

Example: Three times five is more than

(a) 5
(b) 10
(c) 15
(d) 20 answer: (a), (b)

41. Nutritional diseases include

(a) puberty
(b) scurvy
(c) beriberi
(d) rickets

42. Rehabilitation is viewed as a restoration of optimum usefulness for

(a) certain categories of handicapped persons
(b) only those who ask for it
(c) only those who pay for it
(d) everyone as part of their comprehensive care

43. Return to normal eating habits may be encouraged

(a) as soon as the patient is able to be up for part of the day

(b) by surprising the patient with visitors during meal time

(c) by having patients eat in groups

(d) by having the patient sit up to eat

44. "Plan of care" for the patient refers to

(a) the doctor's schedule of visits

(b) the distribution of parcels in under priviledged countries

(c) modification of the patient's manner of living

(d) instructions from a textbook

45. Fundamental needs in sick and well persons include

(a) to feel useful

(b) to eliminate daily

(c) to be loved

(d) to be approved of

46. Feelings or emotions are expressed in such questions as

(a) May I have some water?

(b) Isn't the doctor coming soon?

(c) What day is this?

(d) Do you think I'll get well?

47. The nurse should teach a diabetic patient

(a) how to administer insulin himself

(b) ways of avoiding insulin

(c) how to make insulin himself

(d) how to test urine himself

48. When a physician asks a nurse to teach a pregnant woman how to treat varicose veins, it is professionally correct for the nurse to ask for discussion on

(a) diagnosis

(b) symptoms

(c) treatment

(d) prognosis

49. Valuable pre-training experience for a nurse would be

(a) baby sitting

(b) assistant at summer camp for children

(c) psychiatric treatment following amputation

(d) living with a neurotic relative

50. "Professional nurse" power may be spread by

(a) using attendants and aides for simple cases

(b) having the nurse supervise the care of all patients with a team of helpers, the professional nurse doing only the more complex work

(c) limiting her activities to nursing care

(d) intensive training

Tabulation Sheet

(Hypothetical Scores)

NAME	ITEM 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	Total
Student No. 1	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	49
Student No. 2	x	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	47
Student No. 3	o	x	o	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	o	x	x	x	x	o	x	x	x	x	x	x	x	x	44
Student No. 4	x	x	o	x	o	x	x	x	o	x	x	x	o	o	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	43
Student No. 5	x	x	x	x	o	x	o	x	x	x	o	x	x	o	x	x	o	x	x	x	o	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	43
Student No. 6	x	o	x	o	x	x	x	o	x	x	o	x	o	x	o	x	o	x	x	o	x	x	x	o	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	41
Student No. 7	x	x	x	x	x	x	x	x	o	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	o	x	x	o	x	x	x	x	o	x	x	o	x	x	x	x	x	o	o	x	o	40
Student No. 8	x	x	x	x	x	x	x	x	x	x	o	x	x	o	o	x	x	o	o	x	x	x	o	x	x	x	x	o	x	x	o	x	x	o	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	40
Student No. 9	x	x	x	x	x	x	o	x	x	o	x	x	x	o	x	x	x	x	x	x	x	o	x	x	x	o	x	o	x	x	x	x	x	o	o	x	x	o	o	x	x	x	x	x	x	x	x	x	x	x	40
Student No. 10	x	x	x	x	x	x	x	x	x	x	x	x	x	o	x	x	o	x	x	x	x	x	o	x	o	x	x	o	x	x	x	o	x	x	x	x	x	x	x	x	o	x	x	o	x	o	x	x	o	x	40
Student No. 11	o	x	o	x	o	x	x	o	o	x	o	x	x	o	o	x	x	x	x	o	x	o	x	x	x	x	x	o	o	x	x	x	x	x	x	x	o	x	x	x	x	x	x	x	x	x	x	x	x	x	37
Student No. 12	x	o	x	o	o	x	x	o	x	o	x	o	x	o	o	x	o	x	x	o	x	x	x	x	o	x	x	o	x	x	o	x	x	x	x	x	x	x	x	x	o	x	o	x	x	x	x	x	x	x	35
Student No. 13	x	o	x	o	x	x	x	o	x	o	x	o	x	x	o	x	x	x	x	o	x	x	x	x	o	x	x	o	o	x	o	x	x	x	o	x	o	x	x	x	o	x	o	x	x	x	x	o	o	o	31
Student No. 14	o	o	o	x	o	x	x	o	x	o	x	o	x	o	x	o	x	o	x	o	x	x	o	o	o	x	x	o	x	o	x	x	o	o	x	x	x	x	o	x	x	x	x	x	o	x	x	o	x	x	29
Student No. 15	o	o	x	o	o	x	o	o	o	o	o	o	x	x	o	x	x	x	o	o	o	o	x	o	o	o	x	o	o	x	x	o	x	o	x	o	x	x	o	o	x	x	x	o	x	x	o	o	x	x	22
Student No. 16	o	o	x	o	o	x	x	o	x	o	x	o	x	x	o	o	o	x	x	o	o	o	x	o	o	o	x	o	o	o	o	x	x	o	x	o	o	x	o	x	o	x	o	o	x	x	o	x	o	o	20

x = correct

o = wrong

KEY

1. *F*	26. *a*
2. *F*	27. *b*
3. *T*	28. *c*
4. *F*	29. *c*
5. *T*	30. *c*
6. *T*	31. *c*
7. *F*	32. *k*
8. *T*	33. *j*
9. *T*	34. *n*
10. *F*	35. *e*
11. *37°*	36. *g*
12. *Cath.*	37. *j*
13. *case study*	38. *c*
14. *coma*	39. *n*
15. *passive*	40. *m*
16. *subj've*	41. *bcd*
17. *play*	42. *ad*
18. *need*	43. *acd*
19. *obstetrical*	44. *c*
20. *manic*	45. *acd*
21. *a*	46. *bd*
22. *b*	47. *ad*
23. *b*	48. *abcd*
24. *d*	49. *abd*
25. *d*	50. *abc*

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[1]The table of specifications is largely the work of Professor Margaret E. Hart, Director of Nursing Education at the University of Manitoba, whose generous cooperation is greatly appreciated by the writer.

The simple act of blowing out a book match has now become a medical test. It is used to measure the seriousness of airway obstruction in such pulmonary diseases as asthma or emphysema.

Wheezing and prolonged expiration — the usual bedside signs of airway obstruction — do not give the necessary information to evaluate respiratory function. It is usually evaluated by two rather complicated tests requiring the use of mechanical devices, which cannot always be brought to a bedside.

The match test was devised as a simple bedside means for checking airway obstruction. If a patient is unable to blow out a match held six inches from his mouth, it is a sign that he should undergo the more specific complicated tests.

— *Journal* of the American Medical Association

* * *

The diversity of physical arguments and opinions embraces all sorts of methods.

— MONTAIGNE

* * *

There's not the least thing can be said or done, but people will talk and find fault.

— CERVANTES

* * *

A service beyond all recompense weighs so heavy that it almost gives offense.

— CORNEILLE

In the Admitting Office

MARC TARDIF, M.D.

The role of the admitting office seems obvious enough, but do you know what functions it performs? How it should be set up? Who should be in charge and why?

THE admitting office is a strategic point in the hospital — it might be called the nerve centre. Since its chief function is the admission of patients, it should be located near the main entrance of the hospital, preferably on the first floor and providing easy access to doctors, nurses and other personnel and most certainly for the patient.

The space required will depend on the bed capacity of the hospital and the type of patient care offered. At the very least there must be a waiting room and a private office. The general appearance of this department is important. We should not forget that this is where the patient receives his first impression of the hospital. A pleasant atmosphere and absolute cleanliness are a necessity.

The Personnel

This is composed of the person in charge and the staff. It is preferable to appoint a nurse as head of this department since her professional preparation fits her better than anyone else for this work. She is familiar with medical terminology and doctors' orders. She will be able to grasp the provisional diagnosis which is given by telephone very easily. Her very presence tends to soothe the apprehensive patient. The remainder of the staff is made up of investigators, bookkeepers, telephone girls, and so forth. To this could be added one or more orderlies or commissionaires whose duty it would be to take the patients to their wards.

Need one say that certain very definite qualities in the head of the department and other personnel are prerequisite — sound judgment, a sense of responsibility, patience in abundance and unflagging courtesy.

Dr. Tardif is the assistant medical director at Notre Dame Hospital, Montreal.

The Functions

These may be divided into five main categories:

1. Reservations for admission
2. Admission of patients
3. Discharge arrangements
4. Procedure in case of death
5. Transfer of hospitalized patients

Reservations

The admitting office, in some hospitals, may handle requests for consultations and a complexity of other duties besides. This brief listing of some of the tasks entrusted to it, help us to see the breadth and diversity of the work to be done.

Let us consider each one of these functions in more detail. In the first place reservations may be divided into three groups — routine, public assistance and emergency. Prior to the patient's arrival at the hospital, his doctor will have made the preliminary arrangements that ensure a bed reservation. The patient's name is put on the waiting list along with his provisional diagnosis and the type of accommodation desired. This is the *routine reservation.*

Those people who will require public assistance to finance their hospitalization, if they are not medical emergencies are seen either in the outpatient clinic or by a staff doctor. Then their names are placed on a waiting list until the department controlling public assistance funds accepts the responsibility for their hospital expenses. *If the patient's condition warrants immediate hospitalization,* regardless of his financial status, the admitting office will request authorization from the medical director for priority and the patient will be admitted immediately or with the shortest possible delay.

If admission is not urgent, the name of the prospective patient, the provisional diagnosis and the name of the attending doctor are added to the waiting list. Requests for reservations are then filled in order of asking. The admitting officer forwards a letter to the patient informing him that his doctor has reserved a bed for him and enclosing a form to be filled out which will allow the patient to speed up the process of providing information concerning his identity, employment and financial means when he finally arrives at the hospital.

A problem arises in connection with priority of admission. This is the question of social emergencies. For example: A mother must come into hospital. She can find someone to stay with her children at a specific date. Although her condition is not of an emergency nature, a request is placed with the medical director for approval of it.

The number of admissions is, of course, governed by the number of beds available. When a bed is freed through discharge, the head nurse notifies the admitting office. The waiting list is checked and the next patient is notified according to the type of accommodation desired: male or female, private or semiprivate, financial status and even the service. Sometimes a certain number of beds are allotted to a specific service and only a patient on that service is to occupy one of these beds. However, the hospital beds belong to the hospital, not to the chief of a service or to a specific doctor. The medical director can authorize admission to a service other than the one which will prescribe treatment, if circumstances require it.

It has sometimes happened that a patient has had his discharge written, the admitting office has been notified and the next patient on the waiting list has been advised to report to the hospital whereupon, for some reason, the former decides that he can not leave. This may be the situation presented by an out-of-town patient, brought to hospital by ambulance in his night clothes, given his discharge late in the day and whose relatives cannot be contacted to bring him his clothes. So there you are with two patients and only one bed.

On the other hand, it may be a woman who has been discharged but, of her own accord, decides late in the afternoon that she really is not well enough to go home. In the meantime the new occupant for her bed has arrived. The former patient is not discharged and an average of two or three hours must be allowed before another room can be prepared for the new patient.

These details may seem quite amusing at first but they are everyday occurrences in the admitting office of a big hospital. Often such situations are very irritating. They require a long series of telephone calls in an attempt to find a more or less satisfying solution to these problems.

Admission

The second function of this department has to do with the actual admission of the patient. On his arrival, the patient is identified and a multiplicate admission form is filled out. One copy is sent to the addressograph room to have a master plate made; another copy is sent to the accounts office. Copies are also sent to the records department and the information desk.

When these formalities have been completed, an orderly takes the patient to the particular floor or ward and delivers the admission slip to the head nurse.

One thankless job in the admitting office is accepting the flood of telephone calls directed towards it from every corner of the hospital and from outside as well. There is the anxious patient inquiring if his doctor has *really* put his name on the waiting list: "My doctor told me that I could soon go into hospital and that was three weeks ago!" Most of the time these complaints are made politely. Unfortunately there are times when the language is coarse and even insulting to the person who answers. The staff must often use great restraint in avoiding the temptation to reprimand the ill-bred and badly informed caller. They have to remind themselves that they are talking to individuals soured by illness.

Discharge

The third function is closely allied

to the second. When the doctor, the resident or the intern has discharged a patient, the head nurse advises the admitting and the accounts office. The addressograph plate is sent down to the admitting office and the discharge procedure is a simple one after the accounts office has given its approval.

Procedure at Death

Unfortunately not all patients can be cured and so the admitting office must have some procedure to follow in the event of a death. As soon as the doctor has certified a death, the admitting office is notified and the chart is sent down. There the final diagnosis is entered after consultation with the attending doctor and the cause of death is recorded on the death certificate. The body is removed to the morgue following preparation by the ward personnel. If the death is an unexpected one and members of the family have not been present, they must be notified either by the nurses on the ward or some other designated person. When the official certificate for demography has been filled out, the chart goes to the medical director and the cause of death is entered in a special file. If there is any doubt as to the final diagnosis or cause of death, or if there is something of scientific significance in the circumstances leading to death, the attending doctor or his intern will ask for an autopsy. In some instances, it falls to the lot of the admitting office to get in touch with the next of kin and request written permission for an autopsy. It is a difficult task to have to make such a request from people who are upset by the news of the death of a loved one. We must use tact, understanding and sympathy in our choice of words. The family are overcome by grief and the idea of an autopsy may seem both useless and repulsive. As soon as the autopsy has been completed, the funeral director is notified.

Sometimes when death occurs within 24 hours of hospitalization or following an accident, the law requires that the coroner perform the autopsy. However if the cause of death is obvious, the coroner may dispense with it.

Transferring a Patient

A patient may, for reasons of economy, request transfer from his initial type of accommodation. Sometimes the accounts office may request the transfer because the patient is unable to pay his bills or it may be a ruling of the Medical Board that, in the case of infection or of severe psychosis, the patient must be moved to an isolation room. The attending doctor will ask for the transfer or the head of the accounts office may suggest it to the doctor. This change is noted on the chart and the admitting office is also notified. Often difficulties arise through the lack of isolation rooms or other accommodation desired for transfer purposes. The admitting office has to juggle the bed list and try to find a solution to this problem.

Other Functions

Finally, the admitting office may also be on the receiving end of requests for consultation with another service or another doctor. As the requests for consultation come in, they must be stamped, date and time of their arrival noted, and then they are distributed to the services or persons concerned.

This brief description of the functions of the admitting office, although somewhat incomplete, will give some idea of the scope of work. The responsibilities and the demands of the work make it anything but a sinecure. There is considerable detail and the slightest error must be avoided. The calm of routine can be suddenly shattered by a telephone call reporting an emergency and requesting the ambulance and the intern on duty. Or a patient may arrive unannounced, bag and baggage, for immediate hospitalization. He comes from a distant part of the province; his doctor has told him that he should have surgery done and so with no warning and without even an explanatory letter from the doctor, he boarded the first train for the city. It is up to the admitting officer to sort out this tangle.

The patient can be sent back home again with the very good excuse that he was completely unannounced. However, after he has been seen by the doctor, the admitting officer may realize that he simply can not be sent home again. A place must be found for him somewhere, if only temporarily.

The Nurse and the New Patient

JULIA TRUDEAU

To the nurse, admitting a new patient is one of the most routine duties in her day. She tends to go through the procedure almost mechanically. That is why she needs to be reminded that for the patient, this is a crisis in his life.

THIS IS a familiar theme but one of prime importance in the development of the truly competent nurse. For those who are experienced in nursing, the opinions expressed here may contain nothing new. Nevertheless, let us review the different steps in the admission of a patient from the nurse's point of view. It may prove beneficial to some and give others a sense of satisfaction in a job well-done. The nurse's role will be considered from both the psychological and technical points of view.

In the life of the hospital, the admission of patients is a daily occurrence and, unfortunately, a routine one. This same situation applies to the nurse's work. During her professional career she will admit an undetermined number of patients. However, if this is an every-day event for the nurse, it is not so for the patient. As far as he is concerned, he is the only patient in the hospital and his admission is a major, if not particularly happy, experience in his life. Often it acts as a shock or a psychological trauma. This is where the nurse's role in helping him to adjust under the best possible conditions and with the least stress becomes important. First impressions tend to remain and the nurse should put forth every effort to develop a favorable attitude in the patient towards his hospitalization.

What should the nurse's attitude be towards each new patient? Let us look at the matter objectively. She should see each one as an individual presenting a fresh field for action in physical, psychological and moral care. Her time, her knowledge, her ability should be expended upon each newcomer as if he were the first. She will receive her patient as he should be received — with the kindliness that alone is capable of inspiring confidence. Her expression, her words, and her gestures will convey calm reassurance. She will accept the fact that the patient has a right to her sympathy and her care. She should be compassionate and tactful in helping him adjust to his new state and surroundings and avoid causing him any unnecessary mental anguish. Remembering that this is a suffering human being, dependent upon hospital services, she will observe him closely to determine his personality and his needs in order to understand better his physical and mental reaction to his illness. She will view him within the setting of his social, familial and financial background.

Except under emergency or unusual circumstances, arrangements for admission should be made 24 hours or more before the patient comes to hospital. The admission period should extend over another 24 hours to take into account all those members of the personnel who will be caring for the patient during his stay in hospital. This is an important and necessary step since it fosters a good adjustment to the patient's new environment and activities. Not only is he ill when he come into hospital, but he is away from familiar home surroundings.

In saying that admission arrangements should precede the patient's arrival by 24 hours or more, we also assume that the hospital in question will send out a folder explaining what can be expected on admission. Certain necessary forms could be included and filled out prior to admission, thus avoiding irritating complications on arrival at the hospital. Classification of his illness and reception of the patient into hospital would be facilitated. This procedure will also help to avoid the necessity for transfer following hospitalization. No patient ever appreciates

Miss Trudeau is assistant director of orientation for nurses at Notre Dame Hospital, Montreal.

a sudden transfer from one service to another — and our aim is to keep him as happy as possible.

The patient's arrival at the hospital is set for a specified hour. The admitting office should notify the department concerned far enough in advance to have the new patient received in the smoothest manner possible. The head nurse *must* be warned of all new arrivals since she is directly responsible for the welcome accorded each one. The reception of the new patient will be all the more cordial when she is forewarned and prepared.

On the ward preparation includes inspection of the room for tidiness and cleanliness. The bed covers should be folded back, and the whole appearance of the room should produce a pleasing impression. The observant nurse will see to such details as straightening the drapes, adjusting the window blinds, putting objects back in position. Defective equipment should be restored and any other repairs should be carried out in advance. A squeaky bed, a noisy door, a dripping tap, a stuffy room — all these need to be remedied before the patient arrives.

After being received in the admitting office, the patient is taken to his ward by an attendant who also brings the admission slips carrying the patient's name, address etc. The head nurse, having been prepared of his arrival, gives the patient a friendly greeting and introduces him to the nurse who is to be responsible for his care — perhaps the team leader — and she takes him to his bed.

The patient is almost always accompanied by relatives or friends who, quite naturally, want to go with him to his room. They should be shown every courtesy. They must be reassured concerning the patient's care. Their anxiety must be relieved and their cooperation obtained. Either the nurse responsible for the patient or the head nurse will answer the questions asked by the relatives. Explanations must be clear to help them to understand the requirements of the hospital. By so doing, possible misunderstandings are averted, the patient is helped and the good name of the hospital is protected.

The chart, name plate and identification band are brought to the ward later. It would be very desirable to add the charts from previous admissions or from attendance at outpatient clinics immediately.

After the patient's initial orientation to his environment, the nurse, assisted by the nurse's aide, helps him to get settled. She sees to the convenient arrangement of his personal effects. If he is not in a private room, she indicates the area in the ward that belongs to him specifically. If his clothing is to be kept in hospital, the nurse fills out the appropriate forms. After the patient or, if he is not able, one of his relatives has signed the form, it is attached to the chart. The clothing is labelled and locked away. Valuables, such as money and jewellry, are given to the relatives or to the head nurse. If the head nurse takes responsibility for them, the articles are placed in a special envelope with the patient's name, address and bed number on the outside. The envelope is sealed in the owner's presence and then he signs it. The envelope is placed in the hospital vault after having been countersigned by a responsible member of the business office staff who also gives a receipt to the bearer. The patient must be warned that the hospital takes no responsibility for valuables kept in his possession.

The nurse must instruct the patient in hospital routine as part of the adjustment process. This should be spread over the first 24-hour period. The patient should be introduced to the other people who will be concerned with his care, including student nurses and nurses' aides. The nurse will explain to him that these people make up the team responsible for giving him all the care he may require in the most pleasant way possible. She must be ready to listen to what the patient has to say about his own special problems since it will help her to understand him better. One can often do more good by listening than by talking.

Hospital rules are clarified so that the patient may feel at ease. He is made to understand that the rules are there to ensure smooth functioning of hospital activities. The patient must be familiarized with the physical set-up: the call-bell, intercommunication systems, lights, windows, the bed — if it is raised and lowered electrically,

he must be shown how to operate it, the bed screens, the position of the wash basin, bath and shower. This helps him to feel at home in the new environment which is an important factor in assuring good morale.

If the patient is admitted just at mealtime or slightly after, find out if he has eaten and give him something if he has not and if it is permissible. It is always better to have a doctor's order in this regard. The nurse must carry out certain steps in the patient's care before the doctor's arrival. The patient must undress and either get into bed or be comfortably seated. The nurse must check to see that he is clean and, if not, he should have a bath. If ambulatory, he must be weighed. His temperature is taken. In each instance an explanation must be given. Finally, the nurse should be sure that the patient is comfortable generally and that all necessary details have been attended to before she leaves him.

The nurse's next duty is to give an account of her observations to the head nurse and to call the doctor and intern. The head nurse must check to see that she has sufficient personnel on hand to ensure that all new patients will receive treatment as prescribed. The chart, Kardex and requisition forms must be seen to next.

During the first 24-hour period in hospital, every new patient has various treatments and examinations. It is most important that each one be explained to the patient and that he should be given advance notice. This avoids a fresh surprise each time for the patient and prevents delays or blunders. A physical examination is the first requirement. The nurse must help the patient to understand the necessity for this and she must win his cooperation. She assembles the equipment needed by the doctor and assists with the examination.

The staff on each shift must be made aware of the new patient on the ward. The system of reporting must take into account the steps necessary to ensure continuity of treatment. Use of the Kardex and conferences with the team leaders are methods of notifying each nurse of the new patient's arrival. The nurse is responsible for assigning auxiliary personnel duties in connection with the new arrival.

If this pattern is followed, a superficial attitude is avoided. The patient quickly becomes aware of the sympathetic attitude towards him and the general serenity of the atmosphere. But we still have work to do before we will have attained the ideal in our admission procedure.

Vegetable oils, commonly used in cooking and in salads, have come to the aid of diet-conscious teen-agers, who suffer from acne. Dr. W. R. Hubler, Corpus Christi, Texas, has said that corn oil, used as a dietary supplement, prevented weight loss and fatigue often associated with low fat diets — a frequent acne treatment.

In one group there was remarkable improvement in the skin and general condition of five patients. None of the patients became worse when corn oil was added to their diets. In another group of 180 patients studied, the acne condition seemed to subside more rapidly than in patients treated prior to the use of corn oil. It was necessary to resort to x-ray treatment in only five instances in order to produce clearing of their acne.

Even patients who suffered from acne in its worst form improved with remarkable rapidity with the use of corn oil. All acne patients treated by this doctor now are allowed to use corn oil freely in their diets. Seventy-five patients have also used an unsaturated corn oil oleomargarine on their bread without apparent deleterious effects.

The Texas physician pointed out also that he had found that ingestion of corn oil did not influence the normally low cholesterol levels of the teen-agers in any way.

— *Archives of Dermatology*, American Medical Association.

* * *

Death's no punishment: it is the sense, the pains and fears afore, that makes a death. — Sir John Suckling

* * *

The vagabond, when rich, is called a tourist. — Paul Richard

The Patient comes to Hospital

Denise Fortin, B.Sc. Ed.

No nurse can truly empathize with the patient who is being admitted to the hospital for the first time. Why? She, at least is no stranger to a hospital — for the new patient it is an environment unknown.

The remarks which follow are the results of observations made as a head nurse, and as a patient since I have had this experience on several occasions. To give greater objectivity, the opinions volunteered by certain persons who have been hospitalized at one time or another in their lives, have been added.

This is not intended to be a scientific exposé concerning the psychological reactions of the patient upon admission to hospital. I simply appeal to your feminine intuition and natural understanding when I ask you to consider with me what the human being has to go through when hospitalization is necessary.

We will find that there are as many different reactions as there are patients. Mrs. Brown who arrives in hospital on her own two feet for a medical check-up, certainly will not have the same feeling about it as Miss Kay who is brought to the ward by wheelchair and in great pain, or Mr. White who left his home by ambulance. The chronically ill patient who comes into hospital periodically will exhibit attitudes which may not appear in the person brought to hospital under emergency conditions. All of these categories, if superficially different, have fundamental resemblances when we remember that they are all human beings.

As a first step let us find out what the identifying characteristics of human beings are; what factors relate one to another and draw men together fundamentally, so that we may have a better understanding of the state of mind of the person who must be hospitalized.

Every individual on earth is possessed of a human nature, a nature at once equal and divided, equipped with powers requiring constant use. The powers of thought, of desire, of imagination, of feeling seek expression continually. This manifestation can be easily influenced or changed by circumstances in one's life (illness is one of these), through exposure to a new environment (for example, hospitalization), or through the behavior of those around one. If we admit that individuals possess essentially the same nature, the same psychological make-up, then we must also admit that inherent in their nature are certain basic needs that must be met. What are they?

1. The need for security
2. The need for appreciation, affection, attention
3. The need for growth

Then can you dispute that the human being as he really is tends toward one end—happiness? Having admitted that all individuals, regardless of their differences, are fundamentally the same in nature because of their inherent needs and their common goal, it is much easier to appreciate what takes place in the heart, mind and soul of the person who has to be hospitalized.

From the moment he comes into the hospital, the patient becomes prey to a nagging sense of insecurity. In the admitting office, he must face a barrage of questions which no doubt has a purpose but does nothing to cheer the patient and, in my humble opinion, is not very gracious. I am perfectly aware that institutions must live but is it really necessary to embarrass people to death? I found this procedure difficult to accept but I have confidence that the efforts being put forward to improve the lot of patients in other respects will lead "the powers that be" to devise a more acceptable and less traumatizing method for this aspect of

Miss Fortin is an instructor in the school of nursing, Notre Dame Hospital, Montreal.

the admission procedure.

Upon leaving the admitting office, the patient is taken to his room. At some moment, he finds himself alone, facing the unknown and its disquieting possibilities. He asks himself all sorts of questions.

Why did he come in anyway?
Will he have to stay for long?
What will they do to him?
What will it cost?
How will he be treated?
Will they really be as interested in him as he has heard?
Will he be able to sleep? to eat?
How will he get along?

So many questions, so many answers that it is important for him to have! Will he have a chance to ask about them? With a quaking heart, aching head and an anxious mind, he waits apprehensively. Happily, he finds himself in a hospital with kindly nurses who attend to him as quickly as possible, greet him smilingly, bid him welcome, and explain things to him so that he knows what to expect. Welcoming the new patient properly is so very important! The only welcome that can truly satisfy the new patient's need for security is, I believe, far beyond the rules of protocol outlined in our books on etiquette. It encompasses that attitude towards the sick which is conducive to the necessary and comforting human contact.

Have we not been struck by the effect on the patient of the endless stream of people who go in and out of his room so impersonally, especially in the first 24 hours? Each time the door opens the patient is on the alert. Somebody comes in to take blood; somebody else brings in an examination tray with its mysterious contents. An intern in quest of an interesting "case" to round out his experience as a budding clinician arrives on the scene. The dietitian pays a visit; the nurse's aide brings in a glass of fruit juice (and the patient wonders if he should drink it); the nurse delivers his meal tray; and a representative from a television agency comes in to see if his services are required. Unless the appearance of each one of these various categories of personnel is explained and justified, will not all this coming and going simply serve to increase the patient's insecurity?

Besides the new patient's need for security, which it is so imperative to satisfy, is it not also true that the need for appreciation is similarly imperilled?

Since the normal human being has as much need, if not more, of being respected, appreciated and loved as he has of eating and sleeping, do you not feel that the anonymity with which we tend to surround him during those first few hours in hospital must be distressing? And how about all the labels that we attach to him? They do nothing to personalize him. We should never forget that the patient is a person with a name, a family, social status, with his own views on life and his own special characteristics. He has a personal value that must be recognized. If we want him to feel respected and liked from the beginning, we must look upon him as a man first and a patient last. If we notice that a patient seems to have a feeling of inferiority, everything possible should be done at once to build up his confidence and self-respect.

What other conclusion can we draw from this than the need to show greater consideration for the patient from the moment of his arrival so that we may see him in his true light and by the warmth of our manner lessen the insecurity and anxiety that plague him.

For truth itself has not the privilege to be spoken at all times and in all sorts.
— Montaigne

* * *

The rung of a ladder was never meant to rest upon, but only to hold a man's foot long enough to enable him to put the other somewhat higher.
— Thomas Henry Huxley

* * *

There is great ability in knowing how to conceal one's ability.— La Rochefoucauld



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Happy New Year

Agnes Campbell Neill Memorial Award

Through an educational award, the members of the Nursing Sisters' Association of Canada are proud to honor the memory of Matron-in-Chief, AGNES CAMPBELL NEILL, OBE, RRC, LLD.

A graduate of the Toronto General Hospital, Agnes Neill served for ten years in increasingly important supervisory and teaching positions in her own hospital and school of nursing, latterly as junior assistant to the renowned Miss Jean I. Gunn, superintendent of nurses.

As an international student at Bedford College in 1935-36, Miss Neill gained knowledge of hospital administration which was later reflected in her able organization of the Royal Canadian Army Medical Corps nursing service abroad. From her enlistment in the first month of the war and subsequent assignment overseas as Captain (Matron) until her return to Canada five years later as Colonel (Matron-in-Chief), her record of service to her country and to her calling "tells better than any words the story of Agnes Neill, the woman, the nurse, the officer." To these words every nursing sister whose privilege it was to serve with her, would unquestionably wish to add "the friend."

Returning to civilian life, her great heart for veteran justice naturally drew her to a posting with the Department of Veterans Affairs. But veterans, doctors, nurses and friends everywhere were all too soon to be saddened beyond measure, for Agnes Neill died on the 5th of May, 1950.

As a loving remembrance of a noble, happy person; as a symbol of her outstanding professional leadership; as a continuation of her life's work, the first Agnes Campbell Neill Memorial Award will be made at the time of the 30th Biennial Meeting of the CNA being held in Halifax, June 19-24, 1960.

The following information regarding this Award is presented for the benefit of those nurses who might wish to apply for this scholarship.

AWARD

1. The amount of the Award shall be $500.
2. The Award shall be given every two years to a suitable candidate who is planning to further her nursing education through university study and who meets the requirements set by the Nursing Sisters' Association.

APPLICANTS

1. Applicants for the Award shall be nurses who are registered in a province in Canada. Preference shall be given to:
   (a) Former nursing sisters who have served in Her Majesty's Forces.
   (b) Relatives of nursing sisters or veterans.
   (c) Other veterans who have served in the Allied Forces.

APPLICATIONS

1. Application forms may be obtained from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa, Ontario.
2. The processing of applications will be carried out by the Agnes Campbell Neill Memorial Award Committee with the assistance of the CNA.
3. The CNA will provide professional advice to the Nursing Sisters' As-

sociation or their representatives with regard to qualifications of applicants.

4. ***All applications must be received at CNA Headquarters not later than May 1st, 1960.***

Halifax Headlines

PEARL STIVER, our general secretary visited Halifax in October to attend a meeting of the Sub-Committee of the Committee on Legislation and By-Laws and to meet with members of the Arrangements Committee for the 30th Biennial Meeting, June 19-24, 1960.

Miss Stiver reports that convention plans are well underway. All persons involved in planning, local CNA members, Halifax citizens and the RNANS are enthusiastic in their endeavor to make this meeting a memorable one. CNA members can be assured that the 30th Biennial meeting of the CNA will fulfill their greatest expectations, program-wise and otherwise.

Don't miss this opportunity to meet with old and new friends and to share with our Maritime nurses the results of their endeavors. A warm welcome awaits you.

Action and Reaction

This was the theme of the RNAO Fall Conference held at Honey Harbour, Ontario, October 3-7, 1959. This conference was designed to improve the ability of nurses to work together and with others in identifying and solving problems. About 150 nurses attended, representing hospital, public health and industrial nursing fields. LILLIAN CAMPION, our Nursing Secretary, was priviledged to attend as "Group Trainer." Miss Campion shares with us her impressions of this conference.

MRS. LYDIA HALL, director of Loeb Nursing Centre Project, Montefiore Hospital, Bronx, New York and DR. ROBERT CROOK, assistant professor, Queen's College, New York (they soon became known as Lydia and Bob) led the conference. Mrs. Hall spoke on "Society Health Needs" and in her second talk she gave her concepts of nursing. This she described as a process going on between the patient and the nurse. This process has three interwoven aspects: intimate bodily care, medical care and therapeutic use of self. She emphasized that nurses must help the patient participate in stating his problem and work with him in meeting this problem. There is a need for individuals to verbalize their feelings and nurses should help the patient develop an undertanding of his emotions and to mature physically and emotionally. There was much in her talks to stimulate discussion and provoke thought. The content provided numerous topics for group discussion.

Miss Campion tells us it was a most valuable experience to work with Dr. Crook, an expert in group techniques, in the trainer's role and to observe him put his theories of group work into practice as he so skilfully worked with large and small groups.

The role of a trainer was a new experience to many of the nurses attending the conference. A "group trainer" is not a group leader. Rather, his function is to observe the group process and to intervene when the group seems to be in difficulty. The group trainer may intervene when a group is unable to identify a problem, establish a common purpose or when group antagonisms develop. He helps the group look at what is happening and understand some of the underlying emotions affecting group behavior.

"All work and no play makes Jack a dull boy." Planners for Honey Harbour conferences believe wholeheartedly in this maxim. The daily program consisted of general sessions, small group discussions and recreational periods. Sometimes sessions were held in the evening permitting the nurses to enjoy the fall beauty and splendor of Ontario's Muskoka district in the afternoon sunshine.

Planned recreational activities included a tour of the harbor and part of Georgian Bay by launch, picnic lunch on Beausoleil Island, a barbecue supper and an evening dance. Many nurses enjoyed walks through the countryside and swimming.

All good things must come to an end. Miss Campion returned to Ottawa by car via Algonquin Park which was ablaze with beautiful fall colors — a lovely finale to a most stimulating week.

Fellow of WHO on Study Tour

Miss ALISON CATHIE, instructor at the New Zealand Nurses' Post Graduate School and the recipient of a WHO Scholarship is at present completing a study tour in Canada.

She has visited nursing education centres in four provinces. Miss Cathie is mainly interested in the integration of nursing education into nursing service.

VON House, November 1959

VON House, Ottawa, was the scene of great activity last November when 35 visiting nurses, representing Canada from east to west, attended the biennial conference for regional and district directors sponsored by the Victorian Order of Nurses for Canada.

The theme was Leadership and Interpersonal Relations. Mr. JOHN KIDD, executive director, Canadian Citizenship Council, Ottawa, was conference director, ably assisted by Dr. ALEXANDER LAIDLAW, national secretary, Cooperative Union of Canada; Mr. JOHN HARCOURT, director, Planning and Development Branch, Civil Service Commission; Mr. WALTER HERBERT, director, Canada Foundation and secretary, Canadian Association of Adult Education; Dr. F. R. WAKE, professor of psychology, Carleton University, Ottawa and Miss CHRISTINE LIVINGSTON, Director-in-Chief, Victorian Order of Nurses for Canada.

After identifying the reason for their presence the group sought to identify their problems. Inspiring addresses were given on subjects relating to professional and personal growth, supervision, counselling and guidance, the Victorian Order nurse and her publics and, that ever-present monster, decision-making.

Group discussions followed the main addresses and each group presented their reports to the general session. Discussion leaders were Miss PHYLLIS BURNS, director of Welfare Services, Canadian Welfare Council, and Miss LILLIAN CAMPION, nursing secretary, CNA.

All VON personnel across Canada will benefit from this conference as the directors share with them the wealth of knowledge gained during the sessions. The answer to Miss Livingston's question "Where do we go from here?" will be forthcoming in improved nursing service.

This is a shoe tester for operating rooms that instantly signals the static-charge conductivity of footwear. A person steps onto the instrument's two metal plates located close to the floor. If the shoes are satisfactory, a light on the unit shines. But if the combined resistance of both shoes and body is more than 1,000,000 ohms the light remains off. In that case the shoes must be cleaned thoroughly and tested again.



"Lite-Rite" Shoe Tester

The device, called the "Lite-Rite" Shoe Tester, is equipped with test buttons to show that the unit is in working order and is properly calibrated. For further information write to: National Cylinder Gas Division of Chemetron Corporation, 840 North Michigan Avenue, Chicago 11, Illinois.

* * *

Aspirin may be dangerous for the patient who has a peptic ulcer. Acute gastric hemorrhage has been known to occur usually as a result of acute gastric erosion, even if the patient has an associated duodenal ulcer. A soluble form of aspirin is probably safer if the patient has to receive the drug.

* * *

A doctor who was listening to a woman's ailments and taking down all the pertinent facts, asked her age. Even after repetition of the question there was complete silence. "Oh come now," he finally said impatiently, "just make a wild guess."

Nursing Profiles

The appointment of **Peggy Nuttall** as editor designate of *Nursing Times* has been announced by the Council of the Royal College of Nursing, London, England. She will replace **Marjorie Wenger** who, unfortunately, has had to resign her editorship for health reasons.

Miss Nuttall began her professional career by taking training in physiotherapy at the London Hospital. She subsequently held posts at several London institutions as a practising physiotherapist and as a teacher. Later, nursing attracted her and she entered St. Thomas' Hospital, from which she graduated with distinction in 1955 as winner of the Gold Medal. Miss Nuttall also received the Maternity Prize from the East End Maternity Hospital where she took her midwifery training. Following completion of her professional preparation, she was appointed as a charge nurse at the Royal Waterloo Hospital and later became senior night assistant at St. Thomas' Hospital. In 1958 she came to the staff of *Nursing Times* as assistant editor.



PEGGY NUTTALL

It is with pleasure that we extend warm good wishes to Miss Nuttall in her work with a professional journal that is well-known to Canadian nurses.

It is with great regret that the president and board of management of the Victorian Order of Nurses for Canada have announced the retirement of **M. Christine Livingston.** The nurses who staff the VON units across



(Paul Horsdal Ltd.)

M. CHRISTINE LIVINGSTON

the country, friends, colleagues and acquaintances will echo this emotion with even greater feeling. Miss Livingston has been director in chief of the Order since 1949, having previously served as a staff nurse in Montreal and in various other capacities including assistant superintendent and supervisor with national office. In all she has served the Order for 27 years.

Upon graduation from Hamilton General Hospital, Miss Livingston went to the University of Toronto to study public health nursing. After obtaining her certificate, she returned to the social service department of H.G.H. and subsequently joined the health department of the City of Hamilton. Later she attended Columbia University where she obtained her B.S. degree, majoring in administration and supervision in public health nursing. In 1952 she was awarded the Coronation Medal in recognition of her services.

Her professional connections have been many and varied. She is an officer-sister of the Order of St. John of Jerusalem; a Fellow of the American Public Health Association; a member of the Canadian Red Cross Advisory Nursing Committee, St. John Ambulance Advisory Nursing Commit-

tee, National Committee on Aging and the executive council of the Canadian Public Health Association. As one of our Canadian leaders in nursing, her touch will continue to be felt through the work of organizations such as these.

Regrettable as her retirement from active nursing is, her desire to have the opportunity to enjoy her home more fully, to indulge in the personal pleasures set aside so often to meet professional demands, is most understandable. We wish for her a full and happy life in the years ahead.



(Nat. Defence Photo, Canada)

MAJOR M. E. DEWAR

Margaret E. Dewar was recently appointed for duty on the staff of the Surgeon General, Canadian Forces Medical Services. Major Dewar is a graduate of the Toronto General Hospital. In 1939 she joined the Royal Canadian Army Medical Corps and served in England with No. 15 Canadian General Hospital. Following her return to Canada, she served as matron of military hospitals in Toronto, Kingston, Montreal and Calgary. She was awarded the Royal Red Cross in recognition of her services.

Edna E. Andrews recently retired from the Canadian Army after almost 18 years of service. Major Andrews graduated from the Saskatoon City Hospital in 1931 and joined the RCAMC in 1941. She went overseas in the following year and subsequently served in Canadian general hospitals in the United Kingdom, France, Belgium, Holland and Germany. In 1945 she was made an associate of the Royal Red Cross.



(Nat. Defence Photo, Canada)

MAJOR E. E. ANDREWS

Following her return to Canada in 1946 she served as matron of military hospitals at Calgary, Whitehorse and Toronto. In 1950 she became Matron-in-Chief, RCAMC — the position from which she has announced her retirement.



JENNIE IVES

The Ontario Hospital Services Commission has announced the appointment of **Jennie Evelyn Ives** to the nursing consultant staff. Until accepting this position, Miss Ives had been Nursing Service Secretary with the Registered Nurses' Association of Ontario.

She is a graduate of Belleville General Hospital and has done postgraduate study at the University of Toronto and at Columbia University where she received her B.S. degree, in 1957. Prior to her appointment to the RNAO staff, Miss Ives had served on the faculties of Collingwood General Hospital, McKellar Hospital, Fort William and Toronto General Hospital. In 1943 she became assistant director of nurses at T.G.H. and retained this post until 1957. Her background of professional experience and her administrative ability will be valuable assets in her new field of work.



(Ashley & Crippen)

BLANCHE DUNCANSON

This year the Ontario Hospital Services Commission will establish the Nightingale School of Nursing — a pioneer project of the organization. Directing the activities of the new school will be **Blanche (McPhedran) Duncanson,** a graduate of Victoria Hospital, London, Ont. and of the University of Western Ontario where she obtained her B.Sc.N. degree.

Mrs. Duncanson is widely experienced in the field of nursing education. The present program at Toronto Western Hospital School of Nursing was developed under her guidance during the years 1949-58. More recently she has conducted a survey among schools of nursing in the province of Manitoba; directed a study of registration examinations on behalf of the Registered Nurses' Association of Ontario; conducted institutes in the provinces of Nova Scotia and Quebec relative to the Pilot Project and one in nursing arts at the University of New Brunswick to assist nursing instructors to incorporate principles of nursing throughout the curriculum.

Her acknowledged skill as an administrator and as an educator assures the new school of expert guidance and leadership. The congratulations and good wishes of friends and colleagues are extended to her.

Grace Patterson has been appointed director of nursing for The Toronto Western Hospital. She is a graduate of the school of nursing of this same hospital and since 1950 has been associate director, nursing services.

During World War II Miss Patterson served overseas with the RCAMC and when war ended, was principal matron with the rank of major in charge of No. 12 Canadian General Hospital in France. She was twice decorated with the Royal Red Cross in tribute to her outstanding military service. After her return to Canada Miss Patterson studied hospital administration at the University of Toronto and later completed requirements for her Bachelor of Science degree in nursing at Columbia University.



(Le Roy Toll)

GRACE PATTERSON

Her rich background of experience, her administrative ability, her complete familiarity with the aims and objectives of this hospital and its school ensure capable and devoted guidance of nursing activities.

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- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

Your Name and Address

Talk of Many Things

Helen L. Bolger, B.S.

A summary of the conference of executive secretaries and registrars held in September, 1959.

Professional staff members of the ten provincial nurses' associations and National Office, Canadian Nurses' Association, assembled at McGill University, Montreal, Quebec, for an institute during the week of September 14-19, 1959. Miss Margaret Kerr, executive director and editor of *The Canadian Nurse* was the chairman for all sessions except those held on Thursday, September 17 when Sister Mary Felicitas, Director of Nursing, St. Mary's Hospital, Montreal, and chairman of the national Committee on Nursing Service officiated.

Attention was focused on the responsibility of nurses' associations for leadership in the following areas:

Research in nursing.

Direction of employment relations for nurses.

Facilitation of interprovincial and international registration of nurses.

The first two days consisted of lecture-discussion periods on employment relations under the direction of Miss Frances Goodall, C.B.E., S.R.N., who is chairman, staff side for the Nurses' and Midwives' Whitley Council, Great Britain. The moderator for this session was Mrs. Mary F. Strong, nursing consultant, Personnel Relations, Registered Nurses' Association of Ontario. One day was devoted to a discussion of the understanding of human relationships, the knowledge of conditions under which people work, relationships between various types of staff, and between these and management.

Miss Goodall pointed up quite forcibly that nurses' associations should take responsibility for the direction of employment relations for nurses and provide arbitration facilities for their members. She stated quite emphatically that she did not approve of nurses joining labor unions because they are then a party to strikes which upset the community where they work. As professional people we do not want or need to strike; we can use other measures if we have a proper channel of communication with management. That channel should properly be under the direction of nurses' organizations. For the past few years, nurses in Great Britain have conducted national nurses' conferences to which they invited doctors, hospital and agency administrators. The majority in attendance were nurses, but all were in a position to promote improvement in employment relations for nurses.

On the second day, Miss Goodall gave detailed information on the background, constitution, arbitration, conciliation and disciplinary measures of Whitley Councils. "The name Whitley and the pattern of organization of these Councils stems from World War I," Miss Goodall said. The name honors Mr. J. H. Whitley, a former speaker of the House of Commons. After the First War it was realized that labor relations needed a complete reorganization and a special committee in the House of Commons was appointed to study the question. The terms of reference were: to make and consider suggestions for permanent improvement between labor and management, and to recommend means of improving industrial relations for the future as well as to review these recommendations from time to time. The study of this Committee resulted in five steps:

1. The formation, in well organized industries, of Joint Industrial Councils.

2. The appointment of Joint Works Committees composed of management and staff.

3. The establishment of statutory regulation of wages in badly organized industries.

4. The establishment of Courts of Arbitration.

Mrs. Bolger is executive secretary of the Association of Nurses of Prince Edward Island, Charlottetown, P.E.I.

5. The authorization of the Minister of Labor to hold enquiries regarding disputes.

When the National Health Services Act was passed in 1948 the Minister of Labor was empowered to provide methods of payment of members of National Health Services. At this time nurses gave inspiration in giving direction to the provision of such methods, because the vocation of nursing had been exploited tremendously.

After many meetings of representatives from many of the health professions, it was agreed to have Whitley Councils deal with the problems of management and staff under the National Health Services Act. The Councils were set up under a Royal Charter with definite provision that they did not operate as trade unions.

The functions of these Councils were stated as:

1. To secure the greatest possible measure of cooperation between the authorities responsible for the nation's health and the general body of persons engaged in health services, with a view to the greatest efficiency of the services and the well-being of those engaged in the services.

2. To provide machinery for consideration of remuneration and conditions of work of persons within their orbit under the National Health Services Act.

The Whitley Council, organized on a national basis, is made up of a General Council and nine functional Councils composed of representatives from organizations engaged in health services. Each Council has representation from management and staff (labor). The organizations represent the following health personnel: administrators, clerical workers, ancillary workers, dental personnel, doctors, nurses and midwives, opticians, pharmacists, and other professional and technical workers. Each functional Council has representation from management and staff. There is a consultative group for each functional Council which works hard at getting agreement. Joint staff-consultative measures are employed continuously.

Whitley Councils may be set up on county, regional, community or hospital levels and their establishment is urged through good publicity. On request, groups will receive assistance in organizing from the national level. Such Councils have been set up all over Great Britain. Through them a great many knotty problems are being solved, and satisfactory working conditions are being established for health personnel. Miss Goodall suggested that it is not advisable to establish a Whitley Council in small units where the hospital is under one hundred beds or where the number of personnel in an agency is under one hundred.

As a first step to being organized as a bargaining agent, Miss Goodall said,

> It is necessary to learn thoroughly the history of labor relations in one's own country, the labor laws and social history of hospitals and schools of nursing. It may be necessary to revise existing nurse legislation to become empowered to negotiate regarding labor relations . . . We must remember that unions deal with matters on a material basis, but the professions deal with human elements. We deal in the eternal verities of nursing; vocation, patient and human approach, with the ultimate goals of satisfactory service to the public and a happy and satisfying life for nurses. Nurses therefore need to be good nurses; they should be good members of their profession as well as good citizens.

On September 16, a symposium on "Nurse Registration" was conducted by Miss Frances McQuarrie, registrar, RNABC; Miss Grace Motta, registrar, SRNA; and Miss Muriel Archibald, executive secretary, NBARN. Out of the discussions on registration, the following recommendations were adopted by the members present. The registrars from each province were asked to present these recommendations to the executives of their respective nurse associations and report the reaction of the same in February 1960 at the Registrar's Conference.

Registration of Canadian Nurses by Certification

WHEREAS, In each province there is an authorized body responsible for:

(a) approving schools of nursing

(b) conducting examinations to determine the competency for the practice of nursing

(c) maintaining a register of registered nurses, and

WHEREAS, The integrity of the nursing profession is dependent upon mutual confidence in the standards of

each provincial registered nurses' association, it is

Recommended, That the academic and professional educational qualifications of graduates from Canadian Schools of Nursing who apply for inter-provincial registration be considered acceptable upon submission of proof of:

(a) identity

(b) fluency in English or French, if required

(c) initial registration by a provincial registered nurses' association.

Registration of Non-Canadian Nurses

WHEREAS, Great difficulty has been experienced in evaluating the qualifications (determining equivalencies) of nurses from other countries in respect to:

(a) general academic education

(b) basic nursing preparation

(c) procurement and interpretation of individual nursing records, and

WHEREAS, Standards of nursing care in Canada are dependent upon the proficiency of all persons admitted to the profession and provincial registered nurses' associations are held responsible (usually by provincial statute) for evaluating the proficiency of registered nurses, it is

Recommended, That

1. Applicants for registration who are not graduates of a Canadian school of nursing be required to:

(a) provide proof of identity

(b) provide proof of fluency in English or French, if required

(c) provide proof of certification for nursing

(d) provide a statement of efficiency in nursing employment in Canada for a period of not less than one month

(e) qualify for and pass the registration examination of the province.

2. Applicants for registration, who are not graduates of a Canadian school of nursing be *not* required to write the provincial registration examination if the applicant can present evidence of

(a) success in the registration examination of another province in Canada

(b) success in the N.L.N.S.B.T.P. examination for professional nurses.

The last two days of the meeting were concerned with research and nursing. All the guest speakers for this part of the Institute have made notable contributions in research, each in his or her own right. They were Miss Virginia Henderson, R.N., M.A., research associate, Yale University; Dr. David Solomon, associate professor of Sociology, McGill University; and Dr. Heinz Lehmann, associate professor of Psychiatry, McGill University.

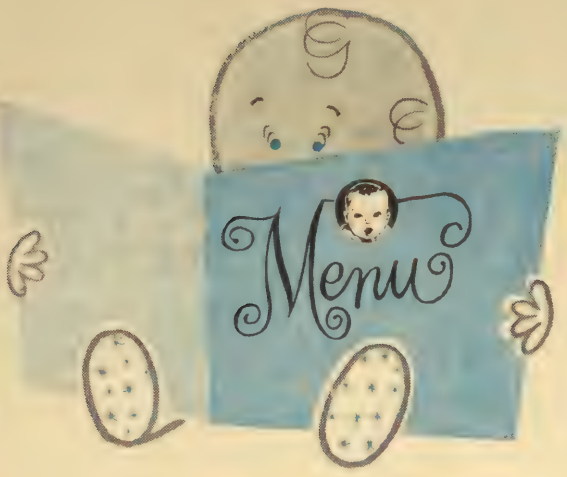
Miss Henderson, who was introduced by Miss Suzanne Giroux, official visitor to the French schools of nursing, Quebec, reminded us that research is not new in nursing. Since 1909 there have been some sporadic studies, but it was not until 1930 that evident interest was shown in applying the scientific method to nursing problems. This approach was adopted in a sincere effort to improve nursing service, nursing education and administrative procedures related to nursing service. The major emphasis at that time was placed on nursing education because there were so many problems stemming from the fact that nursing education programs were based in service agencies. Miss Henderson said

> It has been with the greatest effort that we have taken our schools out of service agencies and into educational institutions . . . The development of the scientific method in dealing with nursing problems has paralleled the development of collegiate nursing education programs. Without this we would not have much, if any, investigation by nurses . . . Because nursing is an applied science, as is medicine, we borrow the sciences and our study is bound to be a composite of the sciences of many fields. Therefore we will have a different concept of research on the one hand from groups of workers whose work is based on research and on the other hand from groups whose work itself is research . . . It is no disgrace or disadvantage to get help to study problems. This will be a great strength in the future — the working together of research teams in the solution of problems. We will need the chemists, the physiologist, the physicist, the sociologist and the psychologist.

An interesting definition which Miss Henderson gave for research was "A structural effort to solve a problem." A good part of the time she spent with us was given to the practical approach to handling a problem in research. She outlined the basic steps for solving a problem and discussed each in detail:

1. Statement of problem.

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Apple Peach
Apple Raspberry
Apricot-Pineapple Dessert
Peach Dessert
Cereal, Egg Yolks and Bacon Breakfast
Ham Omelette Dinner
Bacon Omelette Dinner
Peas and Carrots
Fruit Salad

STRAINED

Bananas with Pineapple
Banana Dessert



2. Review of the literature for identification of similar work.

3. Possible breakdowns or restatement of the problem.

4. Determination of method or design of the investigation. (Statement of assumptions)

5. Collection of data, conduct of experiments, usually including a further study of the literature.

6. Recording of data.

7. Evaluation of data.

8. Report of findings.

It was heartening to learn from Miss Henderson how much assistance the libraries are giving to research workers and how much is being done by universities and libraries to meet their needs.

Dr. Lehmann spoke of the importance of a research attitude and described the typical research personality as one who has "courage, tenacity and a high frustration tolerance." He said that one must be "tolerant to himself as well as tolerant to attitudes and facts." He is such a master of the techniques of research that he made it all sound quite simple and entirely fascinating. In his outline of methods of approach to the solving of a problem, he described some interesting research that is being done in psycho-pharmacology, a specific study of "The psychological effects of wearing colored glasses" and a very mundane study that he and a student of nursing did on the problem of eliminating odors in the room of a patient with an open carcinomatous lesion.

Dr. Solomon stressed the need for formal training in research methods. He answered the question "Can anyone do research? by asking another, "Can anyone do nursing?" He reminded the nurses that there are a lot of current problems that will have to be solved administratively. He cautioned the group not to go beyond their depth in attempting to do research and to secure assistance of specialists where this is needed. "There is a place on research teams for nurses with special preparation to assist with research projects." Dr. Solomon implied that in the future this may well be the area where nurses can make their most valuable contributions to research. However, this will not happen until many more nurses avail themselves of advanced study. Discussion followed here on the need for financial assistance for nursing education, because of the great need for research in nursing and the lack of prepared people to do it.

As one who has had only elementary courses in sociology at school, I was particularly impressed with the topics for research Dr. Solomon suggested as links between sociology and nursing such as:

The anti-therapeutic effect of expecting a patient to perform in a certain way in a hospital.

A study of hostility feelings exhibited by nurses to obstetric patients.

A study of the effect on the head nurse of employing a ward secretary.

Many master's theses in the past have been centred on curriculum studies and the solving of nursing service problems. The above topics presented a completely new picture. It would seem that the days of racking one's brain for a master's degree thesis project are over, at least for a while. Not quite all the problems in nursing have been solved!

At the outset of the conference, welcomes were extended by Dr. Rae Chittick, Director, McGill School for Graduate Nurses and Miss Margaret Wheeler, president, Association of Nurses of the Province of Quebec. The nurses were entertained at teas during the week by the School for Graduate Nurses and by the Association of Nurses of the Province of Quebec.

According to the American Medical Association a vaccine which will prevent from 60 to 70 per cent of all common colds will probably be available within the next 19 months. The researcher believes that a vaccine can be developed against an acceptable proportion of the common cold.

— *Health*, Sept.-Oct., 1959

The not-so-young lady made her first investment in common stock. A short time afterwards her broker called her in some satisfaction to say he had just heard that Procter and Gamble were going to split. "What a shame" was the lady's reaction "they've been together so long."

The Canadian Doctor



Her mother might help, but

SHE'D RATHER TALK TO YOU ABOUT PIMPLES

Only two people easily available to the adolescent can offer advice with assurance that it will be gratefully accepted. One is the mother and the other is the nurse in school, doctor's office, or elsewhere. Actually, the nurse, because of her professional stature and knowledge, can help where a parent often fails.

There is now a clinically-proved medication for pimples* which you can recommend with confidence...CLEARASIL Medication. Many nurses do in fact suggest CLEARASIL —as a recent survey of readers of *RN, A Journal for Nurses,* indicates.

CLEARASIL combines sulphur and resorcinol in a new, scientific, oil-absorbing base. It works with a gentle, penetrating, drying action. And it's antiseptic, to stop bacteria that can cause and spread pimples. Skin-coloured, too . . . hides pimples while it works.

Each package of CLEARASIL contains an authoritative, helpful leaflet on general skin hygiene and living habits. CLEARASIL is guaranteed to help clear skin fast or money back. 69¢ or $1.19 at all drug counters.

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Convention Personality

1960 — a biennial year for the Canadian Nurses' Association and preparations are far advanced for the General Meeting in Halifax. Beginning with this issue some of the persons who are contributing or will contribute to the success of this event will be introduced to the readers. Unfortunately, space will not permit individual tributes to the many nurses working quietly, efficiently and determinedly behind the scenes as members of committees or subcommittees.



(Paul Horsdal)

M. Elizabeth Reed

They are the unsung heroines of every convention, the driving shaft of the whole mechanism of convention organization. Our tribute to them is our acknowledgement of the fact that without their work, there would be no General Meeting.

The first of our convention personalities is **Mary Elizabeth Reed,** the chairman of the Program Committee. As assistant director in chief of the Victorian Order of Nurses for Canada, she is a familiar figure to Canadian nurses. She is a graduate of the General Public Hospital, Saint John, N.B. (now Saint John General Hospital), holds her certificate in public health nursing from McGill University and her B.S. degree in administration and supervision in the same specialty from Columbia University.

Miss Reed joined the VON shortly after her graduation and with the exception of her military service during World War II, the connection has remained unbroken. The years 1942-46 were spent mostly in military hospitals in Canada, England and Northwest Europe. For part of that time she served in the office of the Matron-in-Chief at Canadian Military Headquarters, London, England. In 1945 she was made an associate of the Royal Red Cross in recognition of her military services.

Her professional activities include her duties as chairman, Public Health Nursing Section, Canadian Public Health Association; chairman, Agnes C. Neill Memorial Award Committee, Nursing Sisters' Association of Canada and membership on the finance committee of the RNAO. Her efforts on behalf of the program committee for this Biennial Meeting will reflect the calm efficiency characteristic of her.

Schizophrenia may involve an error in metabolism, an error that may be responsible in turn for the production of excess amounts of some toxic substance or substances in schizophrenic patients.

A study was undertaken at the Department of Neurological Research, University of British Columbia Faculty of Medicine to test this possibility. The method used was the evaluation of the physiological properties of urine extracts from schizophrenics and normal subjects.

As a first step, the over-all effects of these urine extracts on the behavior and spontaneous electrical activity of the brain were studied in cats and monkeys.

Urine extracts were prepared from samples of a group of 20 acute schizophrenic patients at the Provincial Mental Hospital; members of the departmental staff served as controls. Further studies are being conducted to determine whether the differences observed in the over-all effects following injections of the schizophrenic and normal urine extracts are quantitative or qualitative. — *Hospital Progress,* October, 1959



...and you have a **HEADACHE**

"217"

TABLETS

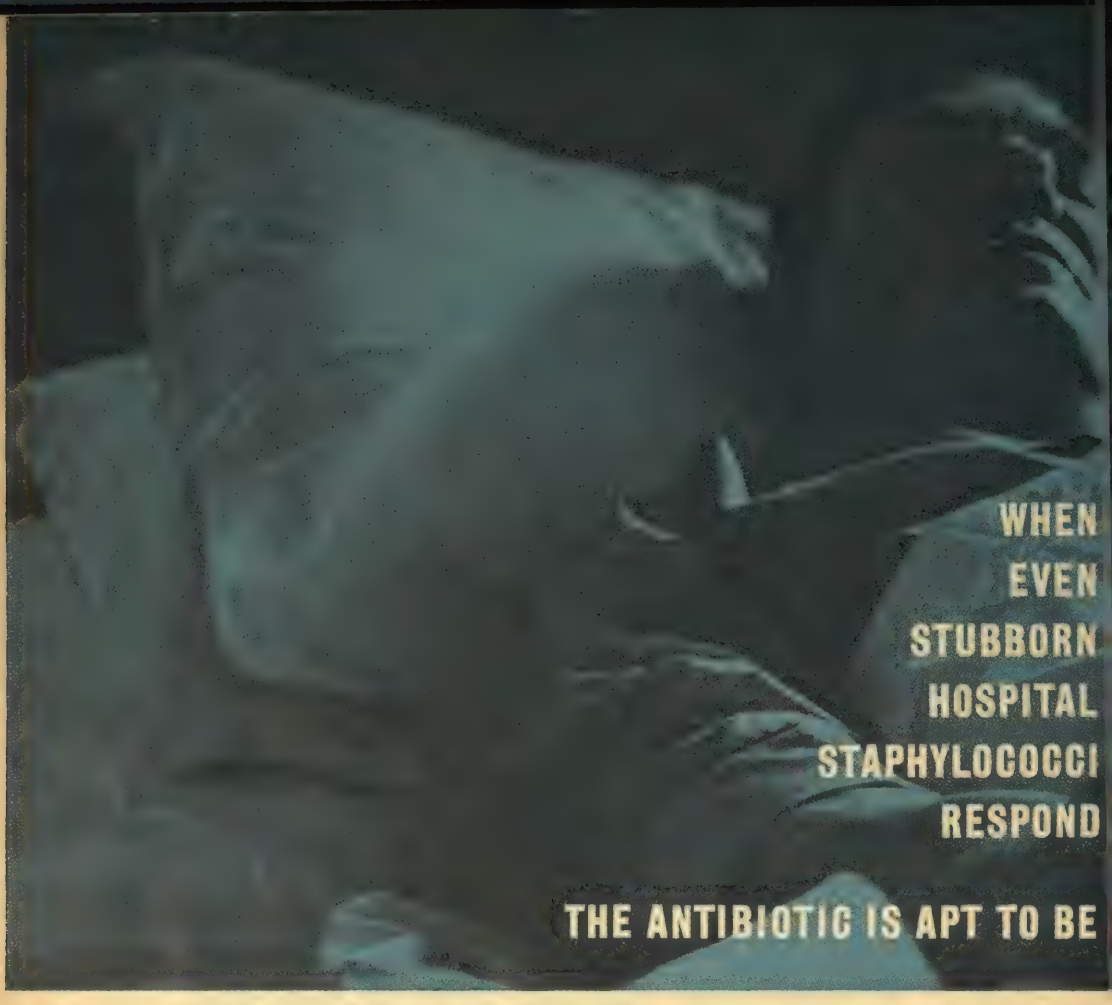
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CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals* of 250 mg., in bottles of 16 and 100.

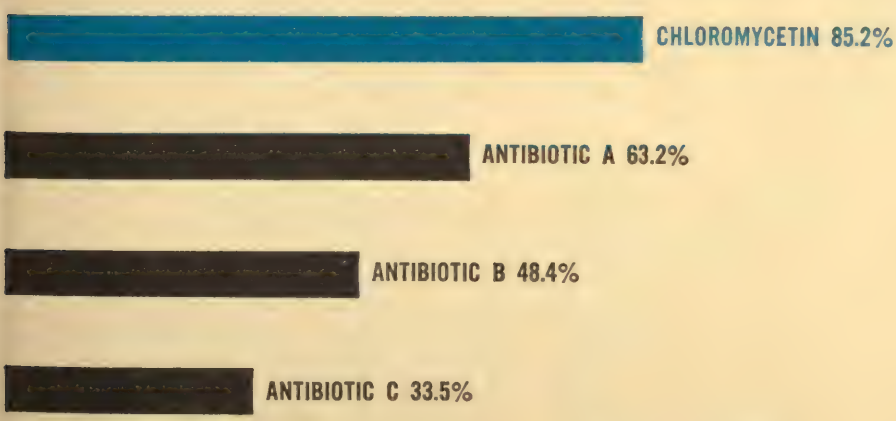
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(1) Goslings, W. R., and Büchli, K.: *Arch. Int. Med.* 102:691, 1958. (2) Flippin, H. F.: *Am. Pract. & Digest Treat.* 10:39, 1959. (3) Borchart, K. A.: *Antibiotics and Chemother.* 8:564, 1958. (4) Fischer, H. G.: *Deutsche med. Wchnschr.* 84:257, 1959. (5) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* 30:175, 1958. (6) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9:38, 1959. (7) Markham, N. P., & Shott, H. C.: *New Zealand M. J.* 57:55, 1958. (8) Ditmore, D. C., & Lind, H. E.: *Am. J. Gastroenterol.* 28:378, 1957. (9) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* 25:52, 1958. (10) Godfrey, M. E., & Smith, J. M.: *J.A.M.A.* 166:1197, 1958.

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General Paralysis

JOHN GIBSON, M.B., CH.B., D.P.M.

Although syphilis may be thought of by some nurses as a disease of the past, tertiary syphilis is found today in those who were infected 10-15 years ago. One of its forms is general paralysis of the insane which now can have a very favorable prognosis.

GENERAL paralysis of the insane (G.P.I.) is a chronic syphilitic infection of the brain and meninges, characterized by progressive dementia and paralysis. It is one of the forms of tertiary syphilis and occurs about 10 to 15 years after the primary infection, most commonly between the ages of 30 and 50. It occurs in only a few of the people infected with syphilis — probably in less than five per cent — an incidence suggesting that a special type of Treponema *pallida* is responsible. It is much more common among men than women. It may be combined with tabes dorsalis in a disease called taboparesis. It can occur as a congenital condition in a congenital syphilitic. The disease is now much less common than it used to be, probably as a result of more effective methods of treating syphilis in its early stages.

The onset of the disease may be insidious extending over several months or dramatically sudden, appearing in a few days. The course of the disease can be described in three phases: an early phase, a middle phase and a late phase.

Early Phase

In this stage the patient begins to show evidence of developing dementia associated with neurological changes. Characteristically, the dementia shows itself in a change of the personality for the worse. The affected person becomes careless and inattentive, makes foolish decisions, cannot concentrate, is easily tired, cannot express his thoughts clearly and is obviously not the man he was. In mood he may be euphoric or depressed, easily moved to laughter or to tears. An admirable account of the progress of the disease is given in Steegmuller's life of de Maupassant who died of it. The patient may have headaches; his fingers become tremulous; he cannot pronounce words correctly. The tone of his muscles becomes reduced, the reduction showing in his face by a loss of the normal folds. His tendon reflexes are commonly exaggerated. His pupils become unequal and show the Argyll Robertson abnormality of loss of reaction to light without loss of reaction to accommodation. He may begin to have epileptic seizures.

Middle Phase

In the middle phase of the illness the dementia progresses further to gross personality changes, a severe loss of memory, crass errors in judgment and loss of normal control. Progressive dementia without mood change is common. About one patient in five is grossly euphoric and exhibits delusions of enormous wealth, cleverness or power: he is a millionaire, he has mountains of gold, he is the strongest man in the world, he has invented the most marvellous machines. A few are depressed, anxious and tearful. Some may alternate between euphoria and depression. Delusions of persecution may develop. Speech becomes even more disordered and more epileptic attacks may occur. Signs of paralysis become increasingly obvious. The patient cannot walk a straight line or stand on one leg. He develops a severe tremor of hands, lips and tongue. He may develop a paresis.

Late Phase

In this final phase the patient becomes markedly demented and incapable of rational thought and speech. Emaciation, physical weakness and muscular paralysis are severe. He becomes bedridden, cannot control his sphincters,

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the fifth of a series of articles on psychiatric subjects.

is very likely to develop bedsores. Eventually he dies.

The outlook for the untreated disease is always bad. Death ensues within two or three years. In some patients a spontaneous remission may check the progress of the disease for some months, but relapse is almost always inevitable. With modern methods of treatment the late phase hardly ever occurs.

The diagnosis of the disease is made on the basis of a history of syphilis, the development of dementia, characteristic changes in pupils and reflexes, a positive Wasserman reaction of the blood, characteristic and diagnostic changes in the cerebrospinal fluid in which the Wasserman reaction is positive, the number of cells increased, the amount of protein and globulin increased, and the Lange curve shows the paretic type, e.g. 55543210000.

Taboparesis shows characteristics of both general paralysis and tabes dorsalis. It runs a much more chronic course than general paralysis and lasts for years. The dementia is commonly of the simple kind. The signs and symptoms of tabes include:

lightning pains — sudden attacks of severe pain in the legs or other parts of the body; visceral crises in which a cute pain and disorder of function occur in organs such as the stomach, rectum and bladder; ataxia with the feet lifted too high in walking and slapped down; blindness due to optic atrophy; loss of sphincter control; loss of tendon reflexes; irregular pupils; perforating ulcers of the feet and Charcot's joints, that is joints which are painlessly enlarged and disorganized.

Congenital General Paralysis is an uncommon development of congenital syphilis. Symptoms develop in adolescence and are similar to those developing in the adult variety. The grosser euphoria and depressive forms do not often occur. The typical picture is that of a gradually progressing dementia.

Treatment

The prognosis for patients with general paralysis of the insane has changed dramatically. This was accomplished first by the discovery of malaria treatment and more recently through the use of penicillin, which is now the treatment of choice. It is very important that treatment should begin as early as possible and before irreparable dementia has been produced.

Penicillin should be given first. After giving small doses for one day to detect unusual responses, it is given daily in doses of 60,000-1 million units until 12 million units have been received. This course may be enough to create a cure and abolish symptoms. Progress may be checked by examination of the cerebrospinal fluid, especially the cell count which, in a cured case, should return to normal. The cerebrospinal fluid should be examined at six-month intervals for one year and then once a year for five years. If there is any relapse the course of penicillin may be repeated.

Malaria treatment is as effective as penicillin but it is much more difficult to perform and has an element of danger. The patient is given an intramuscular injection of 3 cc. of blood infected with the organism of tertian malaria and is allowed to have eight bouts of fever of at least 103°F. The malaria is then controlled by administration of an antimalarial drug such as quinine sulphate. Attacks of malaria do not recur after this treatment.

Standardized Forms for Addressographs

Physicians' Record Company, publishers of Hospital and Medical records, now have a complete series of standardized record forms available for use with addressograph machines. A "Portfolio of Standardized Record Forms for all Hospitals using Mechanical Addressing Equipment" will be sent on request to: The Physician's Record Company, 3000 S. Ridgeland Avenue, Berwyn, Illinois.

* * *

A wrong doer is often he that has left something undone, not always he that has done something. — TERTULLIAN

Infantile Eczema

Ellen Johnson

Few patients exhibit the utter misery of the one with the extensive, angry, itchy eruption of eczema. Treatment is so often a practical application of the old adage: "If at first you don't succeed . . ." Fortunately, this method is frequently successful.

Although medical science has come a long way since the invention of the stethoscope or the discovery of insulin, there are still many hills unclimbed and many phases which lend a challenging, stimulating aura to the profession. What factors in the tissue suddenly cause a normally healthy person to produce new growths, or what constitutional factors suddenly cause a bounding, healthy child to become covered with angry skin eruptions? Of all the puzzling diseases that have been troubling pediatricians for years, eczema is probably one of the most dramatic and most interesting.

Eczema is a relatively common condition of infancy and childhood, often characterized by a reaction of the skin which in most cases has an allergic basis. It causes a great deal of discomfort to the child, and produces much anxiety in the parents. In severe cases, the entire skin surface may be involved, but the most frequent locations are: the cheeks, the scalp, and the folds of the skin — behind the ears, in the neck, axillae, and groins. The disease often commences with a reddening and itchiness of the cheeks, then spreads to other parts of the body. Although eczema is a relatively common condition, its appearance usually provokes numerous problems, many of which may be peculiar to that individual alone. This necessitates a deep understanding of the child's needs emotionally as they relate to this particular disease.

In order to gain an adequate knowledge of a child's emotional and physical background, observation of the parent-child relationship is essential, coupled with personal interviews. Unfortunately, in many hospitals the restrictions on visiting on pediatric wards make adequate parental contact almost impossible. Our knowledge of a child's home environment must be developed chiefly through keen observation of the child, telephone conversations with the parents and information gathered from charts.

When Daniel's parents brought their small, very ill, nine-month-old into our children's ward, his condition was enough to arouse a rather illogical though thoroughly understandable opinion of the parents in the minds of the nurses. The screaming, red-skinned, revolting-appearing baby had made his debut into the field of allergic diseases irrespective of nurses' opinions or the seemingly ineffective parental care he had received. His mother appeared to be a slightly overwhelmed, and rather frightened person of average economic status. She said that the disease had progressed so rapidly that before she had a chance to adjust to her child's changing condition, she suddenly realized that he was seriously ill and should be hospitalized. Later, we learned that about one month prior to his admission to hospital, Danny had been moved from a bedroom that he had previously occupied with his parents, to one that was freshly papered and painted. When questioned about Danny's response to this move, his mother said that she had not noticed any apparent physiological or psychological reaction.

About two weeks later the baby developed dry, red, scaly eczema on the buttocks that spread to the extremities and finally to the body trunk. The condition seemed to become worse after the child had worn a new nylon play-suit. Although Danny had

Miss Johnson is a senior student at Sarnia General Hospital, Sarnia, Ontario.


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had no previously known allergies, the mother realized that an allergic condition was present in this sudden skin condition. She said that she had had several bouts of mild skin reactions when she was a child.

On consulting a doctor the mother was told to try eliminating a great many foods such as vegetables and meats. During this time, not knowing what she could safely give her child, she fed him a great many fruits, to many of which by skin tests later he developed a positive reaction. Upon admission to hospital, Danny's severely eczematous condition presented us with four major nursing care problems namely: diet, identification of allergic factors, skin care, and emotional care.

Diet

To patients suffering from eczema, the identification and elimination of the allergic factors, and the establishment of a proper diet are the gateways to success or failure, especially during childhood. Danny presented a problem in this regard even on a diet restricted to Mulsoy and rice cereal. For about a week his skin showed very little improvement. Mulsoy formula is made of water and a powder of a soy bean base. It is a fairly viscous formula, so was quite easily tolerated by the child at first. This was supplemented with rice cereal, which is light, easily tolerated, and seems to be responsible for few allergic reactions. Danny did not gain weight on this diet, so it was obvious that he would have to be given other foods, especially as he eventually started to vomit his Mulsoy feedings. He could tolerate small amounts given frequently and could drink this from a cup.

After Danny's skin started to improve a little, it was decided he could be placed on an *elimination diet,* in which only one new food is added to the diet at a time. After a new food has been given, the skin is watched carefully for two or three days for signs of a reaction. If no change occurs or if the skin seems to be improving, it is safe to continue giving this food and another new food may then be added. If, however, the skin becomes rough and reddened or in other ways shows an unfavorable reaction to the new food, the child is considered allergic to that food and it is automatically omitted from the diet. Using such a system it is necessary that each person caring for the patient is fully aware of what foods are permitted. A careful list of the foods to which Danny had been satisfactorily introduced was made out and posted in order to prevent mistakes.

Allergic Factors

With the fulfillment of the dietary needs, Danny's skin improved to such a degree that it was possible to do skin tests of 16 different foods. In a skin test, a solution containing protein from the allergen is injected subcutaneously. A careful observation for elevation or redness of the area is made a few minutes later. The nurse's responsibility is first to prepare the child as much as possible beforehand. With a nine-month-old child, this is rather difficult, but the presence of someone with whom he was familiar seemed to help. The nurse should also gently restrain the child with her hands using as little force as possible. It is her responsibility to write down a list of the allergens tried, in the order and formation in which they were injected.

The first skin test was rather unsuccessful as his skin was still too reddened. A later one was tried which proved much more successful and corroborated some of the facts which we had learned from his elimination diet. We could then use the results of the skin test as a basis upon which to build our basic diet.

Before Danny was discharged we tried to teach his mother a few simple principles for eczematous children which could be easily carried out at home. We gave her a list of the foods to which Danny's skin seemed to be negative, indicating which foods had already been tried and could safely be continued. We encouraged her to try new foods, but impressed upon her that only one new food could be tried at a time. We tried to make her as familiar with Danny's diet as possible, in order to prevent frustration on her part which could result in establishing poor feeding habits for Danny. Finally, we told her that if a redness or irritation did occur, she should consider the foods which he had eaten the day before and eliminate any

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doubtful ones. If the condition persisted she should, of course, notify the doctor.

Care of the Skin

The second, seemingly formidable problem, was care of the skin. The most important factor was the application of medications. Before anything was applied the skin was cleansed with a heavy, white, soothing, emollient liquid, the main ingredients of which were lanolin and olive oil. A small amount of the preparation was absorbed during application and the remainder, which contained debris encrustation and sloughed tissue was patted off, using a piece of scorched linen to prevent friction. After applying the preparation, Danny's skin was more soft and pliable. We then applied a thick, dark gray, tar-like paste made of a water-miscible base with zinc oxide and titanium dioxide as the two main ingredients. This not only provided a protective layer over the eczema, but also removed some of the dry, scaly, sloughed tissue from his skin. His cheeks were persistently very reddened and hardened, so a smooth white cream containing polyethylene glycol and propylene glycol was applied to them. This cream, which suppresses allergic dermatoses and skin reactions and decreases pruritus, made his cheeks smoother and softer. Danny's groins and genital areas were very slippery and red. Lassar's paste, which contains a zinc base and is heavier and more tenuous, was applied to these areas. This paste causes the cells to contract making the skin harder and less slippery.

After using the glycol preparation on Danny's cheeks for some time, it was discovered that they were healing up faster than the skin on the rest of his body. Accordingly, the doctor ordered the glycol preparation to be applied to his entire body. This preparation is applied very sparingly and only after the skin is first cleansed with the lanolin. Using this treatment the skin cleared up to such an extent that only the area around his external genitalia remained hardened, elevated, and reddened. Scrapings were taken from the area, and tested for fungi, but the results were negative. Eventually, with use of a controlled diet, proper cleansing, and the application of the glycol preparation, this area, too, cleared up.

Scorched linen is especially effective in conditions such as Danny's because all the lint is removed in a hot oven and provides a soft, non-irritating covering for the tender eczematous skin. Danny's bed was made up using the same kind of linen so that even the bed clothes could do little to irritate his sensitive skin. When giving him his skin treatments, especially during the acute stages of the disease, it was usually better to expose only small areas of the skin at a time. Because his skin was very itchy, he could usually manage to scratch it or rub it in some way, in spite of our efforts, if large areas were exposed at one time. Even a very small scratch would bleed and make his skin even more itchy and irritable. After the skin started to improve, at least half of his body could be exposed at one time.

A stockinette mask with eyes, nose, and mouth cut out, was pulled over his head to protect his cheeks from the bed linen. Danny loved to sit up in a high chair for part of the morning each day. It was not necessary for him to have the stockinette on at this time.

Unfortunately, Danny's condition was such that it was necessary to restrain him with elbow splints. These were put on over the dressings and were removed twice a day for short periods. They could be removed only under supervision lest Danny should find some way to scratch himself. They were padded at both ends to prevent irritation of the skin from pressure. After all the linen dressings were applied and the splints put in place, stockinettes were pulled over arms and legs, and pinned to the diaper. The principle of using splints is to allow the child plenty of movement from the shoulder joint and yet prevent purposeful movements of the elbow joint.

On discharge, some teaching of skin care was necessary in order to extend the doctor's plan of treatment. To cleanse the skin, it was necessary to point out a few facts to the mother. Danny could not have either tub or shower baths until permission was given by the doctor. A very gentle

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sponging with tepid water using no soap seemed best. We tried to emphasize the fact that his skin should be patted dry as rubbing would very easily irritate it. The mother was given a tube of a cortisone preparation to use at times when areas seemed to be becoming eczematous again.

Emotional Behavior

That Danny's disease was closely linked to his emotional behavior was evident almost from the beginning. At first he seemed to be like any other very ill little boy. He was irritable, took his feedings only with persuasion, and cried violently when disturbed for any reason. After the more acute phase of his disease was passed, Danny still produced evidence of emotional upset. He made shrill, irritable crying noises very frequently, often when apparently quite happy. Sometimes he would sit in one position for quite a while and seemed irritable and hypersensitive to any unusual stimulus. Danny needed some one person to cuddle him and form a rather close, personal relationship with him. His condition alone must have caused the very height of frustration without having the feeling of being rejected by those who cared for him added to it. Although a nurse often feels guilty because of the repulsive effect a child such as Danny has upon her, such feelings are natural. By regarding the situation in this light and thus bringing about a deeper understanding of herself and her relationship to the child, the nurse can give him better and more satisfactory care.

Aside from personal relationships, Danny's frustration could have other outlets. Some of it could be lessened by removing his splints as often as possible and by taking off his face mask for a period each day. Sitting in a doorway in a high-chair seemed to provide a maximum of enjoyment for him, so we tried to work this pleasure into his plan of care at least three times a day. He was a very playful little boy so we provided him with several bright, noisy toys.

Before he was discharged, possible emotional problems were reviewed with the parents. Danny was an only child so the attitude of the parents towards him in comparison with other members of the family did not present a problem. However, he seemed to be such a sensitive child that overprotection or even a slight amount of rejection could warp his character. Talking in a matter-of-fact, kindly way to the parents helped them accept and understand.

Danny's growth and development seemed slightly advanced for his age. The anterior fontanel appeared to be closing. He drank from a cup without much spilling. He was partially toilet-trained on admission, but during his illness, he regressed to the point where he was usually incontinent. The linen wrappings and the general frustration from his condition may have been partly responsible for this. Danny crawled around his bed well, and towards the end of his hospitalization, started making attempts to pull himself to his feet. Like most nine-month-olds, he feared strange things or people. For example, he cried violently when placed on the scales or when a strange person entered the room. This apprehension may have been a product of his disease, to some extent, because as his condition improved, his fears became less and less evident. He loved to watch any movement in the room, especially another baby being bathed. He would laugh merrily if a baby made gurgling noises. Danny could handle large toys quite well with his hands. He could grasp a toy or rattle, and shake it expertly.

While caring for Danny, our many challenging problems and our fight for progress instilled in my mind a knowledge of the disease which will undoubtedly prove of infinite value to me in the future.

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Missionary Nurse

MABEL JOHNSON

Combining the positions of director of nursing, nursing instructor and operating room supervisor for a 40-bed hospital would frighten most of us. These, however, are some of the responsibilities of a Canadian nurse in Portuguese West Africa.

IT was Christmas Eve, 1957. We had just finished a lovely evening with one of our missionary families when a message from the hospital arrived. Amelia Baptista was in labor. In a few hours I had the joy of delivering her of twins — both breech presentations. Relatives usually crowd into the waiting room or corridor and what rejoicing, clapping and dancing goes on when a little one — or even twins are born!



Catota Memorial Hospital

How different this scene was some 25 years ago when missionaries first arrived at the Catota Mission Station, in Angola, Portuguese West Africa. No hospital, no nurses, only African midwives working in villages in unsanitary surroundings, with resultant high mortality rates. The Africans of that area are animists and live in fear of evil spirits. If twins were born, surely one possessed an evil spirit, so both would be buried alive. What a transformation has been wrought! Amelia has been a keen Christian for years and now twins bring joy instead of fear to her and to many others.

Early in 1948, Dr. and Mrs. A. C. Henderson of Toronto arrived at Catota. They began building a 30-bed hospital so Dr. Henderson's medical skill was laid aside part of each day in order to supervise the building program which included the making of burnt brick, roof tile, hauling rock, sand etc.

In November, 1948, I arrived, after spending a year studying the Portuguese language in Lisbon, Portugal. My first five months at Catota were spent mainly in learning Nyemba, one of the African languages of that area. I also spent some time in our small three-roomed dispensary and every day we watched the progress in the construction of our new hospital.

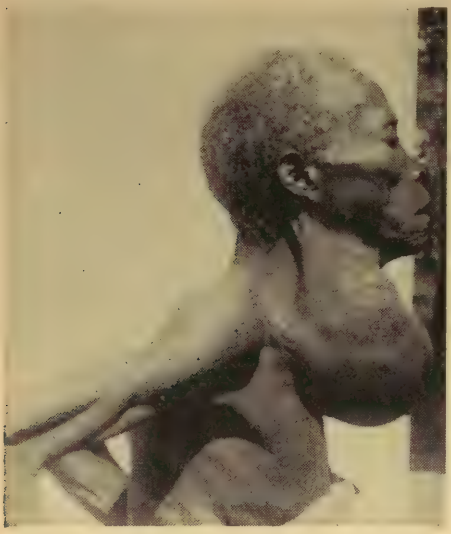
In 1949 the operating room and a few other rooms were completed so we transferred our equipment from the clinic to our new hospital. Patients were flocking in for treatment — badly burned cases, malaria, relapsing fever, pneumonia, tropical ulcers, elephantiasis, schistosomiasis, ameba, anquilostome, tenia, etc. They all needed treatment. Surgical cases also came pouring in and in a few weeks about 40 patients with thyroids, some medium, many huge, came to ask if the doctor couldn't help them. No one seemed afraid of surgery. To them the surgeon's knife could work miracles.

We worked hard getting our operating room ready, sewing laparotomy sheets, drapes, gowns, etc.; washing scrubbing and sterilizing. We had no stove to begin with, so the African masons made an outdoor stove of brick with a round drum cover for the top. If we fed it sufficient dry wood we managed to get our sterilizing done! How we appreciated our "real" stove when it arrived from Cape Town.

Soon our doctor was doing all kinds of surgery — hernias, hydroceles, removal of huge abdominal tumors, thyroidectomies, hysterectomies, excision of breast lipomas (one weighed almost 12 lbs.), cataracts and even spinal

Miss Johnson is at Catota Memorial Hospital, Angola, Portuguese West Africa.

fusions. All this with only one doctor and two nurses!



Hyperthyroidism

From the beginning we realized the necessity of training African nursing assistants. Our first two students, Edwardo Jacob and Herculano Chico, graduated in 1952 and since then over 20 students have completed the three-year course and have received their diplomas. All our students receive a three-month laboratory training. After nurses' graduation, Mr. Edwardo Jacob took postgraduate work and is now in charge of our laboratory. He is very capable and helps in our teaching program. Nurses also have three months in the pharmacy and some time at our leprosarium where we have over 100 patients. Mr. Herculano Chico is now in charge of the operating room and is a very conscientious worker.

Our medical work was growing so quickly that our hospital with its five rooms for clinic was soon too small so we began building a new outpatient department. This was completed last year. We now have room for about 40 beds in the hospital. We have about 125 to 150 patients who come daily for consultation or treatment and our prenatal clinic has about 30 in attendance every Friday. A few years ago only the ones who were having difficulty came. We will soon need a maternity hospital but that may take a long while to materialize as we receive no grants for our work. It is maintained by the free will gifts of churches and folks in the homeland who realize the value of such work.

In 1953 Dr. and Mrs. Henderson and their two children went home on furlough and were unable to return for health reasons. Dr. Regina Pearson was with us for three years and is now in charge of the large leprosarium at Cavango in Angola. We were without a doctor for about two years. Our nearest mission hospital with a doctor was at Dondi, about 175 miles away.

Even though we were without a doctor patients kept flocking in as before. We treated a number who had been mauled by leopards and lions. One was carried by stretcher for three days and by the time he arrived we could smell the gas gangrene even before the wounds were uncovered. He responded well to treatment. He came to greet us at camp last year, and to thank us again for help received.



Miss Johnson and Native Nurses

One day a five-year-old lad was brought in with "bloody diarrhea and abdominal pain." There was no evidence of diarrhea when he was admitted but his spasmodic pain continued and on palpating his abdomen we found he had a small moveable "growth." After pouring over medical books we diagnosed "intussusception." We would have to take him to Dondi immediately. We began our journey over rough roads early in the morning and after a few car difficulties along the way, finally arrived at 7:00 P.M. I gave the anesthetic, the mission doctor operated, assisted by his nurse. The invaginated bowel was dealt with and circulation brought back to the reddened area. The boy's life had been saved and the parents were grateful

to all for his speedy recovery.

These two "doctorless" years were busy, full of interest and varied experiences. However, the responsibilities were heavy and we were very glad last year when Dr. Lois Roberts from California arrived just before I left for furlough and home.

I returned to Angola last autumn and am looking forward to teaching a new group of students, to supervising our 40-bed hospital and operating room. The only other missionary nurse left for furlough when I returned so there were responsibilities in the outpatient department and leprosarium. However our graduates have taken over a great deal of responsibility; without them we could not carry on. It is a joy to see them as concerned about the spiritual needs of their patients, as they are about their physical needs. We seek to minister to the patient in his every need of body, soul and spirit. Healed bodies, lifted spirits and transformed lives make us feel that this work is worthy of all we have to give.



A simple new "breathing tube" for artificial respiration has been announced by Johnson & Johnson Company. Called *Resusitube,* the device is said to be far more effective than any manual method of artificial respiration now in use. It is based on the technique of mouth-to-mouth breathing.

Its uses include: victims of drowning, electric shock, smoke or gas inhalation, drug or chemical poisoning, cardiac arrest, brain injury and shock from blood loss. It is a pocket-sized, S-shaped tube of translucent white plastic. One end acts as a mouthpiece for the rescuer who is stationed at the victim's head. The other end, inserted over the victim's tongue to its base, provides the breathing tube. The rescuer's hands are free to keep the patient's head tilted back and his chin upward. This is vitally important in maintaining an open airway since the passageway is blocked when the patient's head is bent forward. The device is fitted with a flange to prevent air leakage.

Mouth-to-mouth (or expired air-resuscitation) has been widely tested and is now an approved life-saving procedure. The Resusitube makes mouth-to-mouth breathing easier, more effective and more acceptable by eliminating the need for direct oral contact with the victim. In both controlled studies and actual emergencies, it has proven more efficient in maintaining an open airway and providing pulmonary ventilation, and less fatiguing to the rescuer than manual methods.

The tube comes in two sizes, one for adults and children over 3 years; the other for younger children and infants. The retail price is $1.50 for each size.

In Memoriam

Muriel (Young) Aiken, who graduated from The Toronto Western Hospital (formerly Grace Hospital) in 1930, died on June 26, 1959. She had engaged in private nursing for several years prior to her death.

* * *

Adeline (Racicot) Cloutier, a graduate of the St. Charles Hospital, St. Hyacinthe, Quebec, in 1929, died at Sorel, Quebec on September 19, 1959.

* * *

Rachel Drouin, who graduated in 1944 from the St. Vincent de Paul Hospital, Sherbrooke, Quebec, died in September, 1959.

* * *

Claire (Noël) Ducharme, a graduate of the St. Vincent de Paul Hospital, Sherbrooke, Quebec, in 1942, died in September, 1959.

* * *

Catherine Graham, who graduated from the Victoria General Hospital, Halifax, in 1895, died in that city on September 30, 1959. She was a charter and life member of the RNANS and had served overseas in World War I. After the war she joined the staff of the Department of Health and Welfare of the City of Halifax, where she served until she retired in 1953.

* * *

Marjorie Jean (Kirker) Jarrett, a graduate of the Cornwall General Hospital, Cornwall, Ontario in 1951, died on July 3, 1959. She had been living in Rockford, Michigan and was employed in institutional nursing.

* * *

Catherine (Page) Smith, who graduated from The Toronto Western Hospital, in 1931, died on July 11, 1959, at Soldiers' Hospital, Orillia, Ontario. Following several years in institutional nursing, Mrs. Smith was the industrial nurse at Standard Brands Company Toronto until her marriage.

Jane Broadfoot MacLelland, a graduate of Soldiers' Hospital, Orillia, Ontario, in 1922, died on November 1, 1959. She had been engaged in private nursing.

* * *

Alexina Marchessault, who graduated from the Hotel Dieu Hospital, Montreal in 1918 died in October, 1959. She spent five years in the nursing services of Metropolitan Life Insurance Company, following which she joined the teaching staff of the School of Public Health of the University of Montreal. From 1934 to 1940 Miss Marchessault was director of this school. Latterly, she was employed in the Division for the Handicapped, of the Unemployment Insurance Office in Montreal.

* * *

Jessie Bell Monkman, who graduated from Lamont Public Hospital, Alberta, in 1918, died in Toronto, October 7, 1959. She had been engaged in private nursing in Toronto.

* * *

Daisy Evelyn Munnings, a graduate of the Hamilton General Hospital in 1934, died recently. She had been engaged in occupational health nursing.

* * *

Sister Jeanne Phaneuf, a 1921 graduate of the Hotel Dieu Hospital, Montreal, died in that city in November, 1959.

* * *

Florence Tait, who graduated from the Cornwall General Hospital, in 1938, died suddenly on August 13, 1959. Since 1952 she had been on the staff of Women's College Hospital, Toronto.

* * *

(Mrs.) Maureen E. Watson, died recently in Ontario. She graduated from St. Paul's Hospital, Vancouver, in 1954, and had been engaged in institutional nursing.

The sense of humor is the just balance of all the faculties of man, the best security against the pride of knowledge and the conceits of the imagination, the strongest inducement to submit with a wise and pious patience to the vicissitudes of human existance. — Richard M. Milnes

* * *

The whole art of teaching is only the art of awakening the natural curiosity of young minds for the purpose of satisfying it afterwards. — Anatole France

Words are like leaves; and where they most abound, much fruit of sense beneath is rarely found.

— Pope

* * *

The highest possible stage in moral culture is when we recognize that we ought to control our thoughts. — Charles Darwin

* * *

It is futile to expect a hungry and squalid population to be anything but violent and gross. — Joseph Priestley



POSEY PATIENT SUPPORT

Patent Pending

The Posey Patient Support was designed to fill a long-felt need. It is used on wheelchairs or conventional chairs. It is possible to get a bed-patient up into a chair with safety and with no fear of danger. Generously designed to accommodate practically all size patients and all types of chairs. Available in small, medium and large sizes in two models. Standard Model, Cat. No. PP-753, $6.75 each. Adjustable shoulder strap model, Cat. No. PP-154, $7.50 each.

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FIVE OF EIGHT

Though the shortage of nurses is a recurrent problem in many areas, one family has made a notable contribution toward meeting this demand. Mrs. Worrell and the late R. W. L. Worrell, formerly a conductor on the Canadian National Railways, had eight daughters. Between 1935 and 1952 five of these young women graduated from schools of nursing. Robina, Jean and Beatrice chose the Soldier's Memorial Hospital in their home town of Campbellton, N.B.; Elsie went to the Civic Hospital in Ottawa; Rachel, the youngest, enrolled at Royal Victoria Hospital, Montreal.

Two of the sisters are still active professionally though all five have married. Robina, Mrs. R. Day, is on the staff of the Outpatient Department at the Reddy Memorial Hospital, Montreal. Rachel, Mrs. R. W. Fitzgerald, is on the staff of Victoria Hospital, London, Ont. Elsie, Mrs. J. L. K. Marais, is residing now in Cape Town, South Africa. Beatrice, Mrs. S. C. Douglass lives in El Paso, Texas. Jean, Mrs. A. B. Lovelace of Lennoxville, Que. completes this family of nurses.



ROBINA JEAN BEATRICE ELISE RACHEL

Phase II to be Launched

Since June, 1959, the Canadian Nurses' Association has published its official nursing journal in two languages. Despite a few inevitable problems that accompanied the translation of editorial material from either language to the other, the new issue *L'Infirmière Canadienne,* has been well received. Genuine satisfaction with the *Journal* in their native language has been expressed by countless subscribers.

Phase I in this developing program covered the publication of an essentially identical *editorial* content. Phase II provides for the translation of *all the advertisements* that are included in the section of the *Journal* headed "Employment Opportunities." In addition, postgraduate courses given either in hospitals or in universities will also appear in both English and French. A new scale of rates for these dual-language advertisements has been approved by the Journal Board on behalf of the Canadian Nurses' Association. These new rates become effective with the February, 1960 issue. All organizations utilizing the *Journal* for advertising purposes during the past two years were notified last November of the beginning of Phase II.

The rates for line advertisements (classified) will be as follows:

Canada and Bermuda
Three lines or less —$7.50
Each additional line — $1.50
United States and other foreign countries
Three lines or less — $10.00
Each additional line — $3.00

The rates for professional display advertisements that are placed with the Journal directly by an organization are available on request. No discounts or commissions are allowed on these insertions.

All professional advertisements placed through or by an advertising agency will be charged at the commercial advertising rates appearing on the *Journal* Rate Card No. 8. Fifteen per cent agency commission and 2 per cent discount for payment within 30 days of the date of invoice are allowed on these insertions.

All translation costs will be borne by the *Journal.*

International Pediatric Study Tour

This tour was sponsored by the National Council of Nurses of Great Britain and Northern Ireland and the Association of British Pediatric Nurses. The course was held in London, May 3-11, 1959. Seventy-six participants attended and the group included nurses from Australia, Canada, Denmark, Finland, Eire, Germany, Great Britain, Holland, Sweden, Switzerland, Northern Ireland and the United States.

Three Canadian nurses were present — Rosemary Prince, Saskatchewan, Dorothy Richards, Ontario, and Phyllis Lyttle, Nova Scotia. Miss Prince and Miss Richards are graduates of the School of Nursing, University of Toronto, and had been working in one of the London, Eng. hospitals for several months.

The course proved to be most interesting and worth while. Some of the lectures included: family responsibilities; care of children outside of hospital; pediatrics today and the pediatric nurse; care of children in hospital; new diseases; early diagnosis and treatment of cerebral palsy. In addition we visited hospitals, pediatric units, health units, day nurseries, etc.

One afternoon we were privileged to visit either the Royal College of Nursing, the National Council of Nurses, or the International Council of Nurses. Miss Bridges, of the International Council of Nurses, was extremely interested in having us as her guests. Included in the general itinerary was a tour of London and a trip to Cambridge.

On our last night in London we were guests at a dinner in the Dorchester Hotel. Our hosts were the directors of Cow and Gate, Ltd. Each group had a leader who knew London, thus we did not have too many difficulties on the buses or tubes. Miss Rowe, of the National Council of Nurses of Great Britain and Northern Ireland, and Miss Lane, of the Association of British Pediatric Nurses, were extremely kind and helpful.

PHYLLIS J. LYTTLE, R.N.,
Superintendent of Nurses,
Dept. of Public Health.

Book Reviews

The Care of the Patient in Surgery including Techniques by Edythe Louise Alexander, R.N., B.S., M.A. 840 pages, 555 illustrations. C. V. Mosby Company, St. Louis, Mo. 1958. Price $12.75.

Reviewed by Mr. Ralph Coombs, Operating Room Supervisor, University of Alberta Hospital, Edmonton, Alta.

This is a comprehensive text covering every phase of operating room nursing from planning a new operating suite to instructing those people who are to work within the suite. The author has made every effort to assist the nursing members of the surgical team to provide and maintain a safe environment for the surgical patient.

The first section of the text discusses the new operating room, what it should be like and what it should contain. Basic principles of asepsis are well discussed in concluding the section. This portion of the book is of considerable value.

The concluding chapters give a comprehensive coverage to the surgical specialties. Each chapter begins with a review of the anatomy and physiology that is essential to the understanding of that particular type of surgery. This is complemented by a discussion of the basic instruments commonly used by that service, the operative position or positions used and a step-by-step account of some of the more common operations.

This book is well written, concise and thought-provoking. All those interested in broadening their nursing experience in the operating room will find it of great value. Every hospital library should contain a copy.

Education for Nursing Service Administration by Mary Kelly Mullane, R.N., Ph.D. 242 pages. W. K. Kellogg Foundation, Battle Creek, Michigan. 1959.

Reviewed by Miss Dorothy Hibbert, University Hospital School of Nursing, Saskatoon, Sask.

In this book Dr. Mullane skilfully summarizes the accomplishments of 14 universities in developing and conducting programs in nursing service administration on both the Bachelor's and the Master's level of education. These programs were sponsored by the W. K. Kellogg Foundation over a five-year period, 1951-56. This book was also sponsored by the Foundation reflecting their philosophy of their obligation to eval-

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uate and report the results of the programs that they sponsor.

The administration, faculty, students, curricula and research are each described in sufficient detail to provide an excellent guide for the development of similar programs. For example, the objectives of educational programs in nursing service administration are outlined; the desirable qualifications for faculty are listed; the learning experiences and the content of various courses are discussed; samples of questionnaires used to evaluate programs are included. In the final chapter the author raises penetrating questions for consideration in curriculum planning. On what basis should we determine the length of field work desirable? What will be the impact on nursing service in our general hospitals of having psychiatric units, and of giving progressive patient care? What should nursing service administrators be taught about overall hospital administration?

The author is to be commended for the readability of this report. She has compiled pertinent information about the various programs in a skilfull manner and in a style that will make enjoyable reading for nurses interested in curriculum development in the profession; a valuable guide for university faculties in developing similar programs and an important reference for graduate nurse educational programs.

Pharmacology and Therapeutics by Harold N. Wright, M.S., Ph.D. and Mildred Montag, Ed.D., R.N. 497 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 7th ed. 1959. Price $5.00.

Reviewed by Miss Dorothy Wood, Instructor, Grace Hospital, Winnipeg, Man.

The authors had three main objectives in mind for this extremely readable and practical textbook.

1. To attempt to bring us abreast of recent advances in pharmacology and therapeutics.

2. To expand material concerning acid-base and electrolyte balance by a discussion of clinical acidosis and alkalosis and the parenteral use of the various solutions of electrolytes.

3. To discuss, for example, related drugs in connection with the care of the cardiac and hypertensive patient.

The text should be valuable to the student at all levels of her educational experience. The first two or three units deal with the basic material found in earlier editions as well as in most other texts: terminology, drug standards, sources, types of drug preparations. The arithmetic review and calculation of amounts of drug has been reorganized and restored instead of being published separately as in the last two editions. The Canadian as well as American drug legislation is discussed very well.

Illustrative material in the form of diagrams and tables should add greatly to the student's understanding, especially in particular areas such as "Drugs affecting the acid-base and water balance of the body." Bibliographies are to be found at the conclusion of each chapter. They have been revised and brought up-to-date. Included are references to several professional nursing journals. The journals chosen would be available in most schools of nursing.

After the basic material has been discussed the authors relate drugs in the care of patients suffering from various disorders. The patient-centered approach and the nurse-patient relationships are emphasized throughout. In discussing patients suffering from cardiovascular and hypertensive symptoms, there is a concise summary of normal physiology and then a comparison of the normal with the abnormal. Drugs are discussed in relation to this. The usual information concerning source, therapeutic usefulness, action, administration and dosage, toxic effects is given for each drug. The drugs most commonly used as part of the treatment for these patients as well as some newer preparations, are discussed: Digitalis and related preparations, quinidine, pronestyl, nitrites, rauwolfia, Diuril, anticoagulants. The physical and mental comfort of the patient is discussed in relation to some drugs, particularly digitalis. The student is thus made aware of the part that nursing care plays in drug administration.

The questions at the conclusion of each section make the student aware of her responsibilities in the administration of drugs, and of the function of the drug as a means of therapy for the individual patient.

This text appears to discuss the principles of pharmacology without going into too great detail. The student should find the book readable, practical, and as up-to-date as possible. The instructor should find it valuable in guiding her students in the study of pharmacology.

Applied Anatomy for Nurses by E. J. Bocock, S.R.N., S.C.M., D.N. and R. Wheeler Haines, M.B., D.Sc., F.L.S. 326 pages. The Macmillan Company of Cana-

da Limited, 70 Bond Street, Toronto. 2nd ed. 1959. Price $3.00.

Reviewed by Sister Clare Marie, Director, Nursing Education, St. Martha's Hospital, Antigonish, N.S.

This book treats anatomy from a regional point of view, unlike the usual exposition of systemic anatomy found in most texts. It is written in a very concise style, uncluttered by too much detail but adequate enough to give a clear understanding of the subject matter. The content is presented in a very vivid manner, especially planned to stimulate the process of association. This factor, supplemented by excellent diagrams makes the text a valuable teaching aid.

The sections dealing with muscles, both from a diagrammatic and explanatory point of view, are exceptionally well done. Various items stand out because of the manner in which they are elaborated upon, for example, the explanation of why arteriosclerosis is more prevalent in blood vessels of the brain than anywhere else in the body; the mechanism of the coronary sinus; the phenomenon of the closing of the foramen ovale.

Extraneous material appears here and there but the inclusion of it is explained by the authors when they say that they "make no apology for presenting a great variety of interesting facts, for only the student can select those she requires." Since it presupposes that the reader has a basic knowledge of anatomy, this book would seem to serve its most useful purpose as a reference text, both for instructors and students.

Physiology and Anatomy by Esther M. Greisheimer, B.S.Ed., M.A., Ph.D., M.D. 868 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 7th ed. 1959. Price $6.00. (Videograf edition).

Reviewed by Sr. Capt. Ethel Kollin, Director of Education, Grace Hospital, Winnipeg.

The seventh edition of this text was first published in 1957. Although the context is unchanged, there has been a slight revision to allow for the inclusion of a "Videograf" section. This is composed of eight plates of transparent diagrams in color. They show body parts in relation to each other as the Videograf leaves are superimposed upon one another. The layers of the body may be seen from the anterior on the front of the plate and the posterior on the back. This is a worthwhile addition to the book and should prove of considerable value.



PRACTICAL APPROACH TO MICROBIOLOGY FOR NURSES

By Lida S. White and Sr. Sigrid L. Nelson, both of Lankenau Hospital, Philadelphia, Pa. A book of laboratory exercises for beginning students. 127 pages, 1959. $4.00.

UROLOGICAL NURSING MANUAL

By Alfred H. Rossomando. Mercy Hospital, Nampa, Idaho, and Florence M. Miles, Boise Junior College, Boise, Idaho. A manual for student nurses. 112 pages, 27 figures, 1959. $3.75.

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

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General Duty Nurses for all departments. New 250-bed hospital opening early in 1960 in the Niagara Peninsula. 5-day wk. with 3-wk. annual vacation. Residence accommodation available. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses Excellent salary scales & personnel policies. Apply to: Director of Nurses, Parry Sound General Hospital, Parry Sound, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Staff Nurses (4) for convalescent area of 10-beds. Must rotate on all shifts, 8-hr. 5-day wk., good personnel policies, pension policy in effect., 3-wk. annual vacation. 8 statutory holidays. Salary open at present. Apply: Director of Nursing, General Hospital, Stratford, Ontario.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse (qualified for generalized program) R.N.A.O. salary schedule in effect. Apply to: Director of Nursing, Fort William & District Health Unit, 900 Arthur Street, Fort William, Ontario.

Public Health Nurse (Qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,570, starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr. Pension Plan, P.S.I. & Blue Cross benefits Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Rd., Etobicoke, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants, Operating Room Nurse for 100-bed General Hospital in attractive town on Lake Huron. Good personnel policies. Apply to: The Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ont.

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GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $255-$305 per mo. Certified Nursing Assistants $190-$210 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

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FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $260 - $290 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

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REQUIRES

NURSES FOR GENERAL DUTY IN ALL SERVICES.

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Staff Nurses for modern well equipped department, gross starting salary $255 per mo., rotating hours of duty. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

QUEBEC

Assistant Head Nurses; Afternoon Supervisor excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $260 per mo. in effect by February 1960, 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Board & accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in the Montreal area). Excellent personnel policies, working conditions & accommodation in the Nurses' Home. Reply to: Box 1000, Ste. Agathe des Monts, Quebec.

Registered General Duty Nurses for 28-bed General Hospital in Huntingdon, Quebec, 45-mi. from centre of Montreal with excellent bus service. Gross salary $235 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $250; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., Huntingdon County Hospital, Huntingdon, Que.

BERMUDA

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

SASKATCHEWAN

Supervisor (Teaching) to implement program for auxiliary personnel in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary $300 for Saskatchewan registration, $280 for non-Saskatchewan registration. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Operating Room Supervisor for 177-bed hospital to commence duty January or February, 1960, in preparation for taking over the duties of Supervisor in May, 1960. Postgraduate in O.R. technique preferable but not essential. Good personnel policies. For full particulars please apply to: The Director of Nursing, Swift Current Union Hospital, Swift Current, Saskatchewan.

Registered Nurses (2) Certified Nursing Assistants. Salary $280-310 & $180-$210 respectively, 40-hr. wk., 1½-days sick leave per mo., 3-wk. paid vacation, transportation allowance, direct applications to: B. L. Ellis, Secretary, Union Hospital, Coronach, Saskatchewan.

Registered Nurses for new 18-bed hospital with new nurses' residence opening May 1960. We have 4 Doctors on our Medical Staff also Canadian Mental Health Services & Canadian Arthritis & Rheumatism Services. 30 days annual vacation, this includes statutory holidays. Starting salary $260 per mo. which shall be increased in January 1960. Apply: John Uhryn-Administrator, Union Hospital, Davidson, Saskatchewan.

Graduate Nurses for General Duty in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary effective January 1, 1960 $270 or $250 according to registration. 40-hr. wk., 3-wk. annual vacation, 8 statutory holidays, accumulative sick leave. Pension plan available. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

U.S.A.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses (California) for progressive ultra-modern 200-bed hospital (near Beverly Hills), in medical surgical units & operating room. Starting salary $330 per mo. with 6-mo. increase & yearly increases thereafter; 5-day, 40-hr. wk., 8 paid holidays annually, paid vacation, paid sick leave, free hospitalization & life insurance, plus unemployment & disability insurance. Opportunities for advancement & in-service education program. Work in a friendly efficient atmosphere possessing many new time & effort saving devices. Off-duty time may be spent in the sun & social activities of "Southern California Living". Apply Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

-- WANTED --

SUPERINTENDENT OF NURSING

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
JORDAN MEMORIAL SANATORIUM
THE GLADES, N.B.

QUALIFICATIONS: Graduation from a recognized school of nursing, preferably postgraduate study in Tuberculosis Nursing and/or in nursing administration. Registration as a Nurse in the Province of New Brunswick or a province of Canada. Several years of supervisory nursing experience.

DUTIES: The duties of this class involve complex and administrative responsibility performed in directing the nursing and related services in a Tuberculosis hospital.

SALARY: $3,480 — $4,200 per annum; Annual Increment — $180. Salary commensurate with education and experience.

Full Civil Service benefits including three weeks' annual vacation with pay, sick leave benefits, superannuation and retiring leave. Other perquisites available.

APPLY: **CIVIL SERVICE COMMISSION**
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MONTREAL, QUEBEC

NURSING OPPORTUNITIES

Completion of expansion program makes available attractive positions for Registered Nurses in administration and general duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Limited number of bursaries available for post-basic study after one year's service. Residence accommodation in very pleasant surroundings. Within 50 miles of Laurentian holiday and ski resorts. For further information, please write:

DIRECTOR OF NURSING,
JEWISH GENERAL HOSPITAL
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General Duty Nurses for 100-bed County Hospital, accredited JCAH. San Joaquin Valley, 40-hr. wk., liberal sick leave, 3-wk. annual vacation, 12 annual holidays. Starting salary open, range $314-$392, plus $10 shift differential. Rooms in modern nurses' home at $10 per mo. Write, wire or phone: Superintendent of Nurses, County General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses (all departments) **Head Nurse positions** (several) Come to sunny California, 450-bed Queen of Angels Hospital, excellent working conditions, starting salary $330 for Staff Nurses — $380 for Head Nurses — plus PM & Night premiums — merits increase program, vacations, sick pay etc. Apply: Personnel Director, 2301 Bellevue Avenue, Los Angeles 26, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3,860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses (all services) for University of Texas Medical Branch, teaching hospital (air conditioned). Good personnel policies. Base salary, rotation: $290 per mo. Evenings or nights $304 per mo. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

BRITISH COLUMBIA

Fully Trained Nurses (2) Trained Practical Nurses (2) for 60-bed United Church Mission Hospital in northern British Columbia. Opportunity for Christian service. Apply: Medical Superintendent, Wrinch Memorial Hospital, Hazelton, British Columbia.

THE WINNIPEG GENERAL HOSPITAL

is recruiting

GENERAL DUTY NURSES FOR ALL SERVICES

Please send applications direct to:

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THE WINNIPEG GENERAL HOSPITAL,
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Are you a
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Do you enjoy
Nursing
which brings you into
Closer Contact
with your
Patients
and their families?

Are you interested in
Research, Medical Advancement & Rehabilitation?

Have you some or no experience in
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Do you want a
Short Term Appointment
in a unique & useful sphere?

Have you also read the advertisement under Postgraduate Nursing Education?

Then write, giving particulars of your training, to:—

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PEDIATRIC, OPERATING ROOM & PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff.

Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department,
Vancouver General Hospital,
Vancouver 9,
British Columbia

"STOP! IS THIS WHAT YOU ARE LOOKING FOR?" Applications are invited for positions on the permanent or "vacation relief" Staff of a 50-bed active hospital 35-mi. from Vancouver. R.N.A.B.C. Personnel Policies in effect. Apply to Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

NEW BRUNSWICK

Clinical Instructor for 110-bed modern hospital. Personnel policies under revision to be effective in 1960. Apply: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

NEWFOUNDLAND

Laboratory Technician (1, Fully qualified) for 120-bed General Hospital. Salary according to Newfoundland Government scale. 1 way transportation paid. Customary vacation with pay after 12-mo. service plus all statutory holidays. Apply to: H. C. Vincent, Business Manager, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland.

ONTARIO

Director of Nursing for 222-bed hospital under construction in Burlington, Ontario. Position requires Graduate Nurse with extensive teaching, administrative & supervisory experience. This is a challenging post involving the organization & control of the entire nursing staff. Reply by January 31, giving complete qualifications, experience, salary expected & references to: Administrator, Joseph Brant Memorial Hospital, Burlington, Ontario.

Assistant Director of Nursing, Registered Nurses for General Duty for new hospital. Good salary, 21 days vacation, 8 statutory holidays, accommodation available in residence. Apply: Director of Nursing, Miss K. King, Ross Memorial Hospital, Lindsay, Ontario.

QUEBEC

Operating Room Nurses for modern well equipped department in 140-bed General Hospital. No rotation but required to take night calls. Good personnel policies & salary in accordance with A.N.P.Q. recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

ALBERTA

General Duty Nurse for 17-bed hospital, 100-mi. north of Calgary, salary $265 gross with increments of $5.00 every 6-mo. for 3 increases, 44-hr. wk., 3-wk. vacation after 1-year of service, 10 statutory holidays, board & room $35 per mo. Apply: Municipal Hospital, Elnora, Alberta.

SASKATCHEWAN

Graduate Nurses (2) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 3-wk. vacation, plus statutory holidays, 40-hr. work week. Travel fare advanced if necessary. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Staff Nurses for large modern tuberculosis hospital in suburban Cleveland. Nurses eligible for Ohio registration start at $355 per mo. with semi-annual increments. Extra pay for relief & night duty. Opportunities for advancement. Married nurses with families or two (2) single nurses may live in attractive, completely furnished 2-bedroom houses at low, low rent including utilities. 5-day wk., paid vacation & holidays. Liberal sick leave cumulative to 90-days. Retirement plan. Approved by Joint Committee on Accreditation of Hospitals. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

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To direct prenatal Classes and study program of the Prenatal Education Committee, sponsored by the Social Planning Council of Metropolitan Toronto.

Requirements: Registered Nurse, preferably with certificate in public health nursing; preparation and experience in administration and experience in the area of maternal and child care.

Salary: minimum $5,000. Starting salary commensurate with specific qualifications and experience.

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Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical, Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
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WOODSTOCK, ONTARIO.

REGISTERED NURSES
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CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies
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MENTAL HEALTH SERVICES,
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Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:
THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA.
IMMEDIATELY. COMPETITION No. 59:152

PUBLIC HEALTH NURSE
(qualified)
for

City Health Department January 1, 1960 excellent working conditions, including pension plan, hospitalization benefits, etc.

APPLY TO:
MEDICAL OFFICER OF HEALTH,
CALGARY, ALBERTA.

REGISTERED NURSES
required for
MENTAL HEALTH SERVICES
B.C. CIVIL SERVICE

Starting salary $270-$292 per month depending upon experience, rising to $325 per month. Applicants must be Canadian citizens or British subjects and registered, or eligible for registration in British Columbia.

For application forms apply IMMEDIATELY to the:
PERSONNEL OFFICER, B.C. CIVIL SERVICE
COMMISSION, ESSONDALE, B.C.
COMPETITION NO. 59:608

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GENERAL STAFF NURSES
WANTED

To begin January 1, 1960
Salary Reg. N. $265 gross
100-bed hospital

Write:

THE ADMINISTRATOR,
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UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

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GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

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Requires

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$4,620 - $5,160
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$3,900 - $4,560
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Vacancies at various centres throughout Canada

For details, write to
CIVIL SERVICE COMMISSION, OTTAWA
Please quote appropriate competition number.

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AND
CERTIFIED NURSING ASSISTANTS

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Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

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MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal



Residence, Cook County School of Nursing

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$340-$372.50 for a 37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

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- STARTING SALARIES $376 WITHOUT EXPERIENCE, $395 WITH ONE YEAR PSYCHIATRIC NURSING
- STIMULATING AND CHALLENGING CAREERS
- CHOICE OF LOCATION
- PROMOTIONAL OPPORTUNITIES
- REGULAR SALARY INCREASES
- LIBERAL EMPLOYEE BENEFITS

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Eligibility for California License
and
Possession U.S. Declaration of Intention Required

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Write Mrs. Katharine Steele

DIRECTOR OF NURSING SERVICES, DEPARTMENT OF MENTAL HYGIENE
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VICTORIAN ORDER OF NURSES FOR CANADA
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For further information write to:

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GENERAL STAFF NURSES
required
The General Hospital of Port Arthur School of Nursing
Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1-yr. in service.

WRITE:
DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

GUELPH GENERAL HOSPITAL
REQUIRES
STAFF FOR THE FOLLOWING POSITIONS:

Assistant Head Nurses — General Wards (3), General Staff Nurses, Certified Nursing Assistants, Active Hospital 200-beds, Pleasant city 36,000 — 3 colleges. Excellent salary & personnel policies. Additional salary for postgraduate study in specialty.

For further information apply to:
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REGINA, SASKATCHEWAN
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Applications for the Position of
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800-bed, fully accredited General Hospital with large School of Nursing embarking on a two year teaching, plus one year interne, student nursing course effective September 1960. Organization provides Associate Directors in Nursing Service and Nursing Education.
Benefits cover Pension Plan, Group Life Insurance, sick leave, four weeks vacation. Living accommodation available if desired.

Inquiries and applications to be forwarded to:
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NURSING SERVICE DEPARTMENT

NAME (PRINT) .....

ADDRESS .....

.....

BIRTHDAY ..... MARITAL STATUS .....

WHERE REGISTERED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

PROFESSIONAL BACKGROUND

BASIC NURSING & POSTGRADUATE COURSES	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL AND LOCATION	DATE

TRANSPORTATION FROM CANADA PAID UPON APPOINTMENT TO STAFF

COMMENTS:

PLEASE INDICATE IN NUMERICAL ORDER, NURSING SERVICE PREFERRED:

☐ MEDICINE ☐ MEDICINE & SURGERY ☐ PEDIATRICS
☐ SURGERY ☐ OPERATING ROOM ☐ GYNECOLOGY

SEND TO: DIRECTOR, NURSING SERVICE
THE ROOSEVELT HOSPITAL
428 WEST, 59th STREET
NEW YORK 19, NEW YORK



Official Directory

CANADIAN NURSES' ASSOCIATION

74 Stanley Avenue, Ottawa

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Student nurses: one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.

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Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
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Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

Despite the governmental programs for hospitalization in most provinces, or perhaps because of them, new impetus is being given to home care plans. Early in December last, a three-day institute convened in Ottawa to give leadership in the further development of this form of nursing service. A report of this institute is included in this issue.

Home care plan discussions have constituted a major part of the program of the national Committee on Nursing Service as its chairman, SISTER MARY FELICITAS, notes in her guest editorial. Born in Saskatchewan, Sister joined the Community of the Sisters of Providence of Kingston and received her professional training at Providence Hospital, Moose Jaw. She holds her bachelor's degree from the University of Ottawa, her master's from Catholic University, Washington, D.C., where she was awarded Phi Beta Kappa in recognition of her high level of scholarship. Director of nursing education of St. Mary's Hospital, Montreal, since 1945, Sister has been a member of the *Journal* Board since 1952. She represents the nursing sisterhoods of the province of Quebec on the CNA Executive Committee and is very active in her provincial association.

* * *

The twentieth century level of civilization is a far cry from the environment in which our remote and primitive ancestors existed. Excepting in such limited areas as the valley of the mighty Amazon river or a few of the isolated islands in Polynesia, mankind no longer is beset by such catastrophic perils that it has only two major methods of reacting — fight or flight. To permit a human being to respond instantaneously to an acute emergency, two closely associated systems functioned within his body: the endocrine glands that could eject needed substances directly into the blood stream, and the sympathetic nervous system to act as the coordinating mechanism.

Primitive man knew instinctively how to react. The physiological reason why he responded as he did was not known until modern medical research identified the individual parts of this complicated mechanism and discovered their various roles. None of us is concerned about the glandular processes until they get out of hand — either by functioning too actively and becoming "hyper," or by their failure to function properly when they are labeled "hypo."

Both hyperactivity and hypoactivity are included in the articles featured in this issue. How each responds to adequate medical and nursing care is discussed.

* * *

We have departed from our established practice of publishing the same article in the two languages this month. In our English edition, Miss CHRISTINE MACLEOD, president of the Manitoba Association of Hospital Auxiliaries describes the many and varied ways in which the ladies assist the hospitals in her province. Mme. MARGUERITE D. LAMOTHE, president of the Association des Auxiliaires des Hôpitaux de la Province de Québec has outlined the activities of the groups with which she is working.

* * *

From the points of view of both potential students and faculty members of other Canadian universities, one of the most exciting developments that has taken place within recent years has been the inauguration of the first post-baccalaureate program in nursing education at the University of Western Ontario, London. Such a step has been a cherished dream of Dean EDITH MCDOWELL for a long time. You can read her own proud story of what this progressive step means to all of us.

* * *

At the risk of "dating" ourselves, we recently counted back over the number of biennial conventions of the Canadian Nurses' Association we have attended. Our initiation was at the convention held in Regina in 1930. We missed the one in Saint John, N.B. in 1932. That was a depression year and, with small salaries, very few of us could attend. This year's convention in Halifax, will be the fifteenth we have been privileged to participate in. The last time the CNA met in Halifax was 1938. We were younger then, with no rheumatic joints! We travelled both ways — Vancouver to Halifax and return — by bus. It was then and still is a most economical as well as a comfortable way to see the countryside.

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Random Comments

Dear Editor:

Seeing there are so many nurses needed, I have been wondering if there could be refresher courses of a few days on a variety of subjects, i.e., obstetrics, surgical nursing, etc., where one could take only the subjects one is interested in. I myself would not be much interested in surgical nursing but others would be. I was always relieved when that part of my training was over. But I liked obstetrics very much. In fact, my private duty 25 years ago was almost exclusively looking after obstetrical patients in their homes.

I. J., Ontario

Dear Editor:

We have purchased one of your binders for our journals and find it very satisfactory. No definite decision has yet been reached but we are considering ordering more of them if they are still available. Are you planning to continue having them prepared every year?

M. R. T., Alberta

¶ *We have a considerable quantity of these economical binders on hand and shall order more as the supply drops so we welcome your requests for them. No year is stamped on any of them so you can label them as required.* Ed.

Dear Editor:

The Canadian Nurse has shown such growth and professional development these past years that I hesitate to suggest anything that has not been, or is not being, published. Knowing that very few of the younger members either receive or read the articles in the ICN Review, I wondered if you could and would copy that excellent article by Mary Helen Anderson, "The Greatest of These," which appeared in the *Review.*

G. M. F., British Columbia

¶ *Watch for this requested material soon.* Ed.

Dear Editor:

Each time another issue of the *Journal* comes in I think that I will write to let you know how much I enjoy it. I especially enjoyed the October issue for almost the entire number was articles from Quebec nurses. It is most encouraging to have nurses in so many parts of our country writing on such a variety of subjects.

J. S. W., Ontario

Dear Editor:

Regarding the article, "Why Judge Them?" in your November issue by Sister Ste Mechtilde — she had much of worth to say on the subject but she did not say this. While the powerful influence of alcohol is still being felt, why not make it the subject of a discussion? We realize what alcohol can do to the dignity of man.

J. M. W., British Columbia

The Canadian Broadcasting Corporation is presenting a series on nursing on Trans-Canada Matinee. The series can be heard on six consecutive Mondays from January 11 through February 15. Time is 2:30 P.M., E.S.T. but consult your local newspaper for times in other regions.

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 2

MONTREAL, FEBRUARY 1960

Nursing Service Developments

WHAT has been the business of your National Committees this biennium? Although each committee has its specific functions outlined in the By-laws of the Canadian Nurses' Association, all committees aim to assist our members through the formulation of national policies. By their study, or recommendation of studies, various facets of national nursing concern are presented to the Executive Committee which has responsibility for leadership in these areas. Periodically a committee undertakes the preparation of some material which is published because of its usefulness to the membership; to cite just two examples: the Public Relations Guide, and the Orientation Manual.

The Nursing Service Committee directs its attention to matters which promote high standards of nursing in Canada, and which will assist the nursing profession to meet problems of nursing service wherever they may exist. Several topics which come within its scope, have been deliberated by our committee. I have chosen to comment on two of these.

A few years ago, a study of head nurse activities was made under the auspices of the Research Division, Department of National Health and Welfare, Ottawa. This imposing document has been utilized in various ways



SISTER M. FELICITAS

and has been the subject of discussion among many nurses across the country. As a result of this widespread interest, the Committee on Nursing Service began preparation of a guide for head nurses. Four years ago, a special working party laid its foundation. During this biennium, frequent meetings of another such group completed the work. If approved by the Executive Committee, it should be available to all nurses at the June meeting. We hope it will be a valuable tool for all those engaged in the management of a nursing unit.

Home care programs, with their implications for nursing, have also received the attention of our committee. These are organized programs, with centralized responsibility for the administration and coordination of services to patients in their homes, which make provision for at least the minimum of medical, nursing and social services. Such programs may be hospital centered or community centered. Both types are found in Canada and the United States.

Historically, physicians have always provided care in the patient's home. Allied services have not always been available. In spite of attempts to give "comprehensive nursing care" which would embrace provision for all needs of the patient, such care is usually limited to that given within hospital walls. In a visiting nursing program, it is again confined to available facilities. Organized home care would attempt to bridge the gap by bringing together all forces, in a coordinated fashion, on behalf of the patient ill at home, thus extending the facilities of the hospital for such continuous care and for maximum rehabilitation. Whether the responsibility for integration is hospital based or community based, selectivity of patients is essential. It cannot be considered a substitute for inpatient facilities; patients should be placed on home care only when home care best meets their needs. It is necessary that those responsible for administration of the program, as well as the patient and the family, are jointly prepared to meet the needs of the patient.

Such a plan adds to the growing conviction that the hospital is a community service rather than a separate entity for the isolation of disease. It carries the implication that those who work in hospitals may have need to reconsider their role as members of the community in which they live. It is evident that the concept of nursing is broadening in response to the social changes occurring in our midst. The fact that home care plans under both these patterns have been inaugurated in certain areas of Canada and are under active consideration in others, should lead all nurses to review their activities as citizens as well as nurses.

Sister Mary Felicitas,
Chairman
CNA Committee on Nursing Service

Dr. Casimir Grabowski, assistant professor of anatomy, University of Pittsburgh School of Medicine is investigating the effects that oxygen deficiency may have in producing congenital defects in the developing embryo. It is known that oxygen deficiency can produce congenital malformations in mice and chick embryos. When the oxygen concentration of the embryo is reduced in experimental studies gross defects such as cleft lip and palate, anomalies of the heart and great blood vessels and missing or defective extremities are seen to occur. Evidence indicates that oxygen deficiency will also produce malformations in the human embryo. The blood vessels within the embryo seem to be affected by the lack of oxygen and they, in turn, cause more obvious malformations.

Dr. Grabowski is systematically studying the way in which different periods of oxygen deficiency induce congenital malformations in the chick embryo and ways in which the effects of the deficiency can be counteracted. It is expected that both the amount of the deficiency and the stage of embryonic development at which the deficiency occurs will be important factors in the type of malformation which will take place.

Report, Easter Seal Research Foundation

* * *

In uplifting, get underneath. — George Ade

Diagnosis and Management of Adrenal Hyperfunction

W. I. Morse, M.D.

The study of the complexity of endocrine function has long been a "bug-bear" to the student of nursing. The picture of adrenal hyperfunction may become more clear as a result of the following presentation.

The metabolic ward of the Victoria General Hospital, Halifax, provides an example of effective teamwork between the physician and nurse. This close cooperation is very important for the investigation and treatment of endocrine and other metabolic disorders, as I will attempt to show by citing two examples of adrenal hyperfunction.

Before discussing these patients it would be helpful to note briefly the changes which may be expected from excessive secretion of the three major types of adrenal cortical hormones.

1. *Hydrocortisone* is probably the most important secretory product of the adrenal cortex and has a profound effect on the organic metabolism of the body. It stimulates the production of sugar from protein so that when present in excess one might expect an elevated blood sugar level. A large protein loss would be manifested by muscular wasting, weakening of the protein structure of bone and changes in the skin. Hydrocortisone also affects the distribution of body fat especially that around the face and on the trunk. This hormone seems to play a vital part in the response of the body to all types of stress such as injuries and surgical operations.

2. Another adrenal cortical hormone which is essential for health is called *aldosterone*. Among other things this hormone controls the amount of salt which the body retains under different circumstances and for this reason it is important in the maintenance of normal blood pressure and hydration.

3. The third group of hormones is called *adrenal androgens,* but these do not seem to be nearly so essential for health. When secreted in normal quantities they may be concerned with muscular development and the formation of new tissue. However, the excessive secretions of these hormones, occasionally observed in children or women, brings them to the attention of the physician because of the masculinizing effect which they engender. This effect is recognized by premature puberty in the male child and by changes in the body build, voice and clitoris in the female along with hair growth on the face, chest and lower abdomen.

The recognition of an excess or deficiency of some of these hormones is greatly facilitated by measuring their excretion rate or their metabolic products in the urine. These measurements can be very useful in evaluating adrenal function but only if a complete urine collection has been made over a carefully timed 24-hour period. If the specimen is incomplete because of an error on the part of the patient or the nurse it must be rejected. Experience has shown that specimens will be incomplete all too frequently on a busy general hospital ward. For this reason small metabolic wards have been established in many large general hospitals in order to collect urine and stool samples and to perform other specialized metabolic investigations.

Chemical analysis of the urine for its content of cortisone metabolites (17-hydroxycorticoids) is made along with an analysis for adrenal androgens (17-ketosteroids). The determination of aldosterone content involves a much more difficult analysis.

The physician can gain further information regarding adrenal function by injecting a hormone which stimulates the adrenals. This is known as adrenocorticotrophic hormone (ACTH). As might be expected this procedure normally increases the 17-

Dr. Morse is on the staff of the Victoria General Hospital, Halifax, N.S.

hydroxycorticoid and 17-ketosteroid levels in the urine. ACTH is secreted by the normal human pituitary gland in small amounts. Other information regarding adrenal function can be obtained by deliberately suppressing the pituitary ACTH output by the administration of hydrocortisone or one of the newer synthetic steroid hormones. If the 17-ketosteroid excretion fails to drop markedly during such a test an androgen-secreting tumor of the adrenal cortex or the ovary must be suspected.

This brief review of adrenal cortical physiology and the major tests for recognizing adrenal cortical dysfunction may help to clarify certain aspects of the following case reports.

Masculinizing Tumor

A 15-year-old girl had noticed an increase of facial hair one year before admission to the metabolic ward. This was followed by a deepening of the voice and a tendency to acne. On examination, it was noted that there was a fairly marked growth of facial hair and of coarse hair on the chest and abdomen. The clitoris was slightly enlarged but internal examination of the pelvis showed it was normal.

Twenty-four hour urine samples were collected and the 17-ketosteroid content was definitely increased although the 17-hydroxycorticoids were normal. She received Prednisone (a steroid closely related to hydrocortisone) for four days with the expectation that the 17-ketosteroid excretion would drop markedly. In this patient, however, no drop occurred. This made the presence of an adrenal tumor distinctly likely. Special x-rays were taken. These showed no definite abnormality although there was a slight suspicion of a mass in the right adrenal region. Both adrenal glands were subsequently removed by the urological surgeon and although they appeared normal on gross examination, it was considered not improbable that they were the source of the excessive androgen secretion. The ovaries could not be visualized at that time because flank incisions were considered necessary to get good adrenal gland exposure.

A few days after this operation the urinary excretion of 17-ketosteroids was again measured and found to be almost identical with the previous high value. This clearly indicated that the source of her excessive androgens had not been removed and that another operation was required. A few weeks later the patient's ovaries were examined through an abdominal incision and a tumor of the left ovary was removed.

During the postoperative period the 17-ketosteroid excretion was shown to be very low. This proved that the tumor had been the source of the excessive secretion of masculinizing hormone. The pathologist felt that this tumor had the appearance of adrenal tissue — obviously displaced adrenal tissue which had undergone neoplastic change. The patient has done well since her second operation and much of the excessive hair growth has now disappeared.

As a result of the removal of both adrenal glands this girl must have a small dose of cortisone or some related steroid each day in order to survive. During the first few days following both of her operations this cortisone was given intramuscularly because of the uncertainty of using the oral route at that time. The need for intramuscular cortisone or intravenous hydrocortisone is increased at such times.

The following incident demonstrates the importance of frequent observation by the nurse immediately following bilateral adrenalectomy. Fifteen hours following surgery it was noted by the nurse that the patient had a pulse rate of 140 per minute. The chart of the pulse and respirations had been carefully completed and indicated that this increase in pulse rate had occurred gradually during the previous few hours. The wound dressings had been checked and indicated no excessive blood loss at the site of the drains. The physician was notified and a larger dose of intravenous hydrocortisone was prescribed. This was followed by a reduction in pulse rate and general improvement in the patient's condition. The nurse's role in this incident prevented more serious acute adrenal insufficiency.

Bilateral Adrenal Hyperplasia

A 43-year-old woman was known to have had high blood pressure for seven years and had sustained a marked weight gain with fat accumulation on

the trunk and neck during the past five years. She complained of weakness, headaches and had had a cerebral vascular accident three months before admission. A growth of coarse hair had also become apparent on the face during the past five years suggesting increased adrenal androgen secretion. The blood pressure was 205/125. The fasting blood sugar level was increased.

The distribution of body fat, the hypertension and hyperglycemia suggested Cushing's syndrome although the muscle mass and radiological bone evaluation were not abnormal. The 24-hour 17-hydroxycorticoid excretion was definitely increased. This offered strong support for the diagnosis of excessive hydrocortisone secretion. The 17-ketosteroids were normal. Following intravenous infusion of ACTH the normally expected increase in 17-hydroxycorticoid and 17-ketosteroid levels occurred suggesting that the adrenal glands were hyperplastic rather than the site of a steroid-secreting carcinoma.

Both adrenal glands were exposed by the urological surgeon and were found to be slightly enlarged. Both glands were removed resulting in a marked drop in the urinary excretion of 17-hydroxycorticoids and 17-ketosteroids.

The patient now takes a carefully determined dose of cortisone and fluorohydrocortisone each day. She is maintaining a normal blood pressure and normal blood sugar concentration. The excessive hair growth on her face considerably improved. Her weight is down from 283 to 226 pounds on a reducing diet but this obviously leaves much to be desired.

Untreated Cushing's syndrome is often fatal and these patients stand the stress of operation poorly. The early postoperative course of this patient will demonstrate the close cooperation required between physician and nurse.

During the first 24 hours after bilateral adrenalectomy her systolic blood pressure could be maintained above 90 mm. only by continuous infusion of noradrenalin. A special nurse was assigned throughout this period and numerous visits by the physician were necessary to adjust fluid and hydrocortisone therapy. Two to four days later several episodes of dyspnea occurred. One of these episodes was due to atelectasis. This was undoubtedly the result of the pain associated with coughing and the obesity which made it extremely difficult to turn the patient. A portable chest x-ray was taken which proved of no diagnostic value. This pointed out the necessity of movement by the patient so as to clear the atelectasis. Further pulmonary collapse was avoided by frequent turning by the nurses and by assisting the patient during coughing. A few days later a severe episode of dyspnea was associated with evidence of pulmonary embolism. She survived this with the help of anticoagulant therapy but a few days later it had to be discontinued because of bleeding from both incisions. This patient illustrates the stormy postoperative course which many cases of Cushing's syndrome experience.

The chief purpose in relating the above case reports has been to demonstrate the team work required between physician and nurse in patients with adrenal hyperfunction. Any large general hospital is well advised to have a metabolic ward staffed by alert nurses with training and experience in the highly specialized procedures which this type of work involves.

A 24-page illustrated booklet entitled "Home Care of the Child with Rheumatic Fever" has been prepared especially for parents of youngsters for whom hospital treatment is either not advised or not available. It contains practical pointers on home nursing techniques and suggestions for dealing with the psychological and emotional problems that are likely to arise when a youngster is confined to bed for more than a week or two.

This new booklet is issued as a companion piece to "Have Fun . . . Get Well" a publication on recreational activities for the child who is confined to bed. Both are published by the American Heart Association, 44 East 23rd St., New York 10.

* * *

It is notorious that the memory strengthens as you lay burdens upon it, and becomes trustworthy as you trust it.

— De Quincey

Nursing Care in Adrenal Hyperfunction

Joyce T. Elliott

Nursing care of the patient with adrenal hyperfunction is interesting and challenging. Learning here is truly an ongoing process.

During the first eight years of its existence, our metabolic ward has housed a wide variety of patients. They come from two sources. Some are referred directly by the doctors of the metabolic ward staff, others from the wards of the main hospital. The latter are screened before admission to determine whether the condition is suitable for the special studies presently being done in the unit.

Diabetics are always on the ward, as well as patients who require assessment of thyroid function. Some receive radioactive iodine therapy for the treatment of hyperthyroidism. It has been fascinating to watch their progress. There have been many patients admitted for observation and adjustment of replacement therapy following hypophysectomy. This operation is done to alleviate the unhappy state of metastatic involvement of the bony structure in those who have had carcinoma of the breast. Many patients are admitted for assessment of adrenal function.

Shortly after the ward was opened a 13-year-old boy was admitted, who presented a typical textbook picture of Cushing's syndrome. A unilateral adrenalectomy was performed revealing a benign adrenal tumor. Jimmy was a very rewarding patient for within two years he had grown into a normal young person. Fat pads no longer hid his ears, the buffalo humps had disappeared from the back of his neck, and there was a marked decrease in the striae on the skin of his abdomen and extremities. The precocious sex interest that had been of such concern to his parents, and had been one of the main reasons for bringing him to the doctor's attention, was now notably modified.

Two years ago a lady was admitted who was remarkably cheerful when one considered her general appearance. She was of medium height, large frame, with a total body weight of 283 pounds. The obesity was centripetal, sparing the limbs, her face was moon-shaped and hirsute. There was a buffalo-type pad of fat on her back and intertrigo beneath both breasts. The mother of seven children, five years prior to admission she had had a hysterectomy. It was during these five years that her great weight gain had occurred. Hair growth on her chest, pubic area, axillae and legs had greatly increased. She shaved daily and was troubled by acne on her face and chest. Other complaints were shortness of breath with nocturnal dyspnea, palpitation, frequency and nocturia.

Following a bilateral adrenalectomy she was returned to the metabolic ward from the hospital recovery room, and placed in an oxygen tent. Intravenous apparatus was attached to both legs, permitting maintenance of blood pressure over 90 mm. systolic, by alternate administration of Solu-cortef and Levophed. On several occasions when a sudden drop in blood pressure occurred we had to raise the foot of the bed.

Immediately postoperatively her urinary output was small and highly concentrated. There were frequent episodes of rapid pulse and respirations with cold and clammy skin. Inflamed areas developed about the site of the Levophed infusion and did not respond well to an injection of Rogitine. She had a troublesome cough, pain about the operative areas and a definite tendency for the skin over the coccyx to break down. This was successfully prevented by the use of tincture of benzoin. Her oral intake was slow in reaching satisfactory fluid and caloric amounts. She developed a fondness for remaining in the oxygen tent longer than the doctors felt was warranted.

Few patients could have presented

Miss Elliott is on the staff of the Victoria General Hospital, Halifax, N.S.

a more definite picture of discomfort after a conscientious struggle had been made to make her comfortable. On being questioned she unfailingly stated that she did not feel at ease. She developed pain in the right leg which proved to be thrombophlebitis. Hot compresses were applied to both legs and eventually to the operative areas. Inability to retain oral cortisone necessitated the continuance of the intramuscular type. She was also given aminophylline, heparin and benadryl. She was able to sit up on the side of the bed on the ninth postoperative day. There were no further complications.

At regular intervals this patient has returned to the ward for re-assessment of her requirements for replacement therapy and for general recheck. Several unhappy family incidents have continued to complicate her obesity problem, and have perhaps prevented a successful response to operation.

The second patient for bilateral adrenalectomy was young and weighed 148 pounds.

Her postoperative course was remarkably uneventful with the exception of the instance that Dr. Morse has described. While commenting on the difference in the progress of the two patients, he explained that the boy with Cushing's syndrome had a stormy course because of the impairment of his general health by this condition.

The third patient returned to normal oral intake promptly. Oral cortisone was started on the second postoperative day. The next day she sat up in a chair and continued to increase her activity daily. She was discharged from hospital on the 13th day after operation.

On re-admission in four weeks she said that she felt that she was in much better health, but her hirsutism had increased. She remained on the unit until re-evaluation of her steroid levels was completed. She was then transferred to the main hospital where a left salphingoophorectomy was performed.

Now, her hirsutism is steadily decreasing and the control of her replacement therapy is very satisfactory.

Celiac Disease

Hubert O'Hanley, M.D.

There is as yet no satisfactory explanation for the development of celiac disease. However, our knowledge of the food factors involved in its occurrence has increased. This has given us the key to a means of control although not of cure.

Celiac disease is essentially steatorrhea which is the result of malabsorption of fats from the intestinal contents due to changes produced in the physiological function of the intestinal mucosa by certain foods in a manner as yet not understood. The clinical picture presented by the patient with this disease varies according to its severity and duration. Many children have only prolonged or recurrent diarrhea without any significant effect on their general growth or development. Others are reduced to a state which is characterized by severe cachexia with loss of muscle and fat, a huge protuberant abdomen, marked anemia and weakness, and increased susceptibility to infection. The round red cheeks of these children in sharp contrast to their general emaciation is an intriguing facet of a disease that holds fascination for many who are interested in clinical research.

Diagnosis in the advanced case rarely presents difficulty. A history of prolonged diarrhea characterized by gruel-like stools and associated with body wasting and abdominal distention immediately indicates the condition. In infancy specific laboratory examina-

Dr. O'Hanley is the head pediatrician in the children's department of the Charlottetown Hospital, Charlottetown, P.E.I.

tions may be necessary to differentiate fibrocystic disease of the pancreas from celiac disease. These examinations have become so accurate and simplified that determination of the specific disease is no longer very difficult. In older children laboratory tests may be employed, particularly in those who are not severely affected, to confirm the clinical diagnosis. These tests are based on poor absorption of fat so that the demonstration of increased amounts of fat in the stool remains of prime importance in diagnosis.

It has long been known that the malabsorption characteristic of celiac disease was related in some way to particular foods in the diet. For many years fats were believed to be the offending agents because of the increased amount of fat that appeared in the stool. Then starches were shown to be responsible for celiac disease in many children. In recent years protein in the form of the gluten fraction of wheat and rye has been shown to have a deleterious effect on the majority of celiac patients. Whatever the offending component of food, the manner in which it produces its ill effect is not understood. One researcher stated that very careful examination of the gastrointestinal tract at autopsy failed to reveal any abnormal histology. In recent years many attempts have been made to demonstrate abnormal pathology in celiac disease but as yet no definite correlation has been established. The pathophysiology of celiac disease remains unsolved.

The complications of celiac disease in addition to body wasting and general debility include a number of specific deficiencies related to the loss of fat in the stools. The fat soluble vitamins are excreted in large amounts and the patient may show lack of vitamin D and vitamin K especially. Concurrent with vitamin D deficiency is the loss of large amounts of calcium in the stool. Rickets and tetany are therefore frequently associated with prolonged celiac disease. Anemia is often marked. Plasma proteins may be reduced sufficiently to lead to edema. The general debilitated state makes these patients very vulnerable to infection and recurrent episodes are common.

The treatment of celiac disease may be simple or complicated. If gluten is the offending food, a gluten-free diet results in dramatic improvement in the child's health and remission of the disease complex. On occasion when a gluten-free diet does not have the expected results, other forms of dietary management are necessary. Sometimes considerable difficulty is encountered in selecting the proper foods for elimination. Starches in particular need careful evaluation in the diet of a child who does not respond to gluten-free foods. It also appears that fat may, on occasion, be the dietary factor needing restriction.

The essential thing is to achieve a diet that the child can tolerate and which also provides him with adequate intake for proper growth and development. His diet should be palatable, especially if marked anorexia characterizes his illness. Additional amounts of water-soluble vitamins are necessary adjuncts and calcium should be supplied generously. Anemia, if present, requires specific therapy. To bring a child from cachexia to robust health may require many months of controlled treatment. When this happy result is achieved, it may be inadvertently lost by reverting to a normal diet. This happens when the parents believe the child to be cured and no longer in need of restriction of diet after he has been clinically well for months. It is very important that the parents should be educated to realize that celiac disease is *never* cured but only held in remission by dietary control.

Those who have lost an infant are never, as it were, without an infant child. They are the only persons who, in one sense, retain it always. —Leigh Hunt

* * *

Has any reader ever found perfect accuracy in any newspaper account of any event of which he himself had inside knowledge?
— Edward Lucas

* * *

To him who is in fear, everything rustles.
— Socrates

The Celiac Child's Diet

Sister Joan Mary, C.S.M., M.A.

Raising a child who has celiac disease presents subtle problems. Keeping to a rigid diet involves more for the mother than the mere exclusion of certain foods.

Over a period of years numerous dietary plans have been proposed and used in the treatment of children with celiac disease. Invariably they depended on the elimination or restriction of starches and fats. Since 1950 one of the causes of celiac disease has been attributed to an intolerance to gluten (or gliaden) in wheat and rye with the starch fraction considered harmless. Many patients have responded to a gluten-free diet. However, a few still fail to thrive satisfactorily on this diet and require restriction of other foods such as potatoes, fats and foods high in residue.

The exclusion of wheat and rye flour eliminates bread, cake, pastry, gravy and soups thickened with flour, together with buns, biscuits, and other foods. Celiac patients react only to the protein in wheat (gluten) and can take wheat starch without harmful effects. Gluten is separated from wheat on a commercial basis and the product — pure wheat starch — can be readily obtained. It costs only slightly more than ordinary flour, and is used as a substitute. The bread, though quite palatable, is less easy to make than ordinary bread. It is crumbly and heavier because of the lack of the dough-making property of gluten. Angel cake and cookies can also be made with this flour.

The gluten-free diet is not difficult to give at home. The main problem is the presence of small quantities of wheat flour in a wide range of manufactured products not clearly of wheat origin, for example: ice cream, canned cream soups, canned meats, packaged puddings, mayonnaise, macaroni and spaghetti, as well as other foods of unknown origin. One child had a recurrence of symptoms by eating one serving of canned meat. The parents should have a list of the foods the child has to avoid as well as of those allowed. Apart from the total exclusion of wheat and rye gluten, the diet in many cases is normal.

Obviously, the cooperation of the parents is essential in caring for the celiac child. They must be persuaded to adhere to the diet rigidly as even a small amount of gluten is enough to bring on a recurrence of symptoms. One mother in speaking of her celiac child stated "If he ate the crumbs from the carving board, when I was cutting the home-made bread it was enough to bring on diarrhea."

Getting the child to accept a diet free from gluten requires weeks of unlimited patience and persuasion. All children as soon as they become conscious of the actions of adults and other children tend to imitate them. Consequently, they not only want to eat what they see adults eating but demand foods other children ask for, such as bread, cake and ice cream. One mother reported solving this problem by substituting those foods with lollipops and sherbet. Her child could eat both without difficulty and did not feel deprived of all sweets.

The parents' emotional attitude to the word *diet* has a great deal to do with their willingness to see that the diet order is carried out on an individual basis within prescribed limitations. Their psychological reaction will mirror the habitual pattern of response of the individual child. It must be remembered also that the appearance of food has a psychological effect on the celiac child as it has on any one. Everyone seems to relish food which is attractively prepared and served on colorful

Sister Joan Mary, a staff member at Charlottetown Hospital, P.E.I., has recently completed the requirements for her master's degree at University of St. Louis, Mo. Her graduation thesis was on this topic.

dishes with an added garnish. Pleasant surroundings and cheerful company will do much to win the cooperation of the older child in accepting the foods allowed on the diet.

Dietary restriction may cause feelings of embarrassment in a celiac child who cannot accept foods others enjoy. The need for special foods along with some restriction of his activity, further contributes toward making a child feel different. To avoid unpleasant situations it may be helpful to limit parties. In this way the child is not faced with a variety of foods he cannot have and fatigue is also avoided by not partaking in play that causes over-exertion.

Social difficulties are also existent in carrying out the diet. One is that of ensuring a gluten-free lunch for a child who must take his lunch to school.

The following recipes are made with gluten-free flour:

Gluten-free Loaf

1⅞ cups gluten-free flour
4 tablespoons sugar
4 tablespoons butter or margarine
4 teaspoons baking powder
milk as required

Sift dry ingredients into a bowl. Rub in butter. Mix in enough milk to make a batter consistency. Mix lightly and pour into a greased tin. Bake in a quick oven for 10 minutes. Then reduce to a moderate heat for a further 30 minutes.

Angel Cake

4 eggs
¾ cups sugar (white)
½ teaspoon vanilla
¾ cups sifted flour (gluten-free)
1 teaspoon baking powder
¼ teaspoon salt
2 teaspoons lemon juice

Place mixing bowl over pan of hot water. Add eggs and sugar; beat until mixture is lukewarm. Remove from heat, then beat until the mixture resembles whipped cream. Add vanilla. Cool. Sift flour or wheat starch, then add baking powder and salt; sift again. Gradually fold dry ingredients into egg mixture, using spoon or wire whisk. Fold in lemon juice. Gently poor into ungreased pan — (9-inch tube pan). Bake in 350° F. oven 35-40 minutes, or until cake springs back when lightly touched with finger. Invert on rack 1 hour. Loosen sides of cake with a spatula; remove from pan.

Diabetes Mellitus

G. Greaves *and* Elizabeth Ward

Prescription for the diabetic — full life or mere existence? To understand is to cope, to fear is to fail.

Diabetes mellitus is a chronic disease of metabolism associated with an insufficient supply of insulin. Secreted by the beta cells of the ductless glands of the pancreas or islands of Langerhans, insulin is necessary for the metabolism of carbohydrates and therefore for fat metabolism.

The first step in carbohydrate metabolism is the conversion of the glucose that is not needed for immediate energy, into glycogen so that it may be put into temporary storage. For this conversion to take place the glucose must be transported through the cell membrane; one theory widely held today indicates that insulin in some way promotes this transportation. The process of conversion, called *glycogenesis* takes place largely in liver cells. It is to be noted that diabetic patients have very little liver glycogen.

The second step is *glycogenolysis*, the opposite of glycogenesis, is the reconversion of glycogen to glucose and its transportation outward through

The authors are graduates of the Royal Columbian Hospital, New Westminster, B.C.

the cell membrane. Insulin appears to be necessary for glycogenolysis also. Two other substances influence this process, both by stimulation of it. They are: epinephrine which is present in excess amounts during times of stress, and the hyperglycemic factor, glucagon from the alpha cells of the islands of Langerhans.

Insulin and thyroid hormone both exert control over the rate of carbohydrate catabolism — insulin because it promotes glucose transport into cells so that it is available for oxidation and thyroid because it accelerates the oxidation reaction.

Insufficiency of insulin may be due to fibrosis of the islands of Langerhans or an actual decrease in the number of these structures.

Incidence and Prevention

Diabetes is chiefly a disease of older people, the incidence increasing steadily with age and reaching a peak between the years of 65 and 75. The incidence of diabetes is increasing for three reasons:

1. Diabetics live so much longer now that the disease may be controlled.
2. Diabetics are having so much more children.
3. The average duration of life of the entire population is lengthening.

Diabetes is hereditary, with one person in four inheriting the tendency. A diabetic should therefore not marry another diabetic and should avoid marrying into a diabetic family. The older the age of the patient when diabetes is diagnosed the milder the disease will be.

The disease is more common in people who are overweight. Above the age of 30, 80 to 90 per cent of potential diabetics are overweight before they develop the disease. The mother who gives birth to an infant weighing 12 pounds or more stands a 100 per cent chance of later becoming a diabetic herself.

Diagnosis and Management

The onset of diabetes is usually insidious. The patient may experience no symptoms whatsoever or he may report any or all of the classical triad: polyphagia, polyuria, polydipsia. There may be an accompanying weight-loss, weakness, drowsiness, vague aches and pains, dryness of the skin and mucous membrane. The diagnosis is usually made on the findings of hyperglycemia and glycosuria. The objectives of management are as follows:

1. To compensate for the metabolic insufficiency by the administration of insulin, or an oral hypoglycemic agent, by diet or by a combination of drugs and diet.
2. To attain and maintain an ideal body weight.
3. To prevent complications.

The following two nursing care studies illustrate the way in which these objectives were met for individual patients, at different stages of their diabetes.

Infection as a Complication of Diabetes

The Patient

Mr. Thomas was admitted to hospital with a diagnosis of "diabetes out of balance." He was a 39-year-old man who had lost a great deal of weight over the past few months. Despite the fact that he was very uncomfortable, he was cheerful. He had a wonderful outlook on life.

The fact that he was a diabetic had changed his way of life very little and the special care that he had to take because of his illness fitted in naturally to his daily living. He told me that he follows his diet carefully and when he goes out to dinner, either he or his wife supervise the type and quantity of food served to him. Fortunately his diet has not been too much of a hardship for him as he does not like sweet things. He feels that this is nature's way of keeping him from eating high caloric foods. Occasionally he uses saccharin in his tea or coffee.

He did not recall ever having experienced diabetic coma, but occasionally when he had had too much exercise he had experienced mild shock. He carries lumps of sugar at all times, to be taken if he feels weak or begins to perspire freely. He has thus prevented serious insulin shock, but is aware that this may occur and therefore carries a diabetic identification card.

He has been very careful to rotate the sites of injection and no lumps appears on his arms or legs. He also realizes that special care to his feet is essential.

In order to understand his illness more fully Mr. Thomas has read several books on diabetes mellitus, and while in hospital never passed up an opportunity to learn more about his condition.

During my conversations with him he told me that there was a history of diabetes in his family. Although his father did not have the disease, some of his father's brothers and sisters did. Mr. Thomas has six children including two sets of twins. His eldest child is a daughter of 14. The children are checked every six months by the family physician. Both he and his wife, who also thoroughly understands the disease, are watchful for signs and symptoms in their children.

Past History

This is the fifth time that Mr. Thomas has been hospitalized for control of his diabetes. When the condition was first diagnosed it was regulated with diet. After losing 40 pounds he remained free of glycosuria for six months, but thereafter it was necessary for him to take protamine zinc insulin. Two years later he came to hospital because of painful swelling of both legs, which was attributed to thrombophlebitis. He improved with treatment only to return the following year with an infected ulcer on his right leg. A culture isolated Staphylococcus *pyogenes*. Five days later he was discharged to be treated further at home.

Present Illness

Mr. Thomas suddenly developed diarrhea. It lasted for about three days and was followed by an attack of "influenza." Before he was completely well again he developed moderately severe pain in the region of the right ischial tuberosity. The pain came in spasms, was not relieved by aspirin and only partially relieved by the application of heat. Two weeks later he was admitted.

When the doctor talked to Mr. Thomas he discovered that the patient had visited his mother in California the year before because she had become ill with pulmonary tuberculosis. A chest x-ray was taken which proved negative. An intradermal tuberculin test was done using strength 1:10,000. The results were suspicious so another was done with strength 1:1000. This test proved negative. An x-ray of his right hip showed no definite lesion but his elevated sedimentation rate and white blood count and a temperature which remained between 100° and 102° F, indicated a hidden infection.

The white blood count normal is 5,000 - 9,000. On admission it was 14,700, ten days later 21,450. Sedimentation rate normal is 0-10 per hour. Mr. Thomas' was 105 per hour on admission and remained high.

A diagnosis of rectal abscess proved negative on sigmoidoscopic examination. The final diagnosis was "diabetes with severe infection of unknown etiology or site."

Medication and Treatment

The infection caused Mr. Thomas' diabetes to be "thrown out of balance." His Clinitest read + 4. His fasting blood sugar was as high as 257 per cu. mm. of blood, normal being 80-120. On admission he was given a 3,000-calorie diet and 50 units of protamine zinc insulin once daily. (This is a long-acting insulin with onset of action in 4 - 6 hours, duration 24 - 36 hours.) As his Clinitest continued to be + 4 he was given a 2800-calories diet and 55 units of isophane insulin (N.P.H.) (This type of insulin is made from zinc insulin crystals modified by protamine. It acts within 1 - 2 hours and lasts for 28 - 30 hours.) Repeated Clinitests indicated + 4 with the Acitest strongly positive. Protamine zinc insulin was tried again, 80 units daily, but it did not bring the diabetes under control. He was then given 35 units of plain insulin q. 6. h. For the first time during his hospitalization his Clinitest dropped to + 1. (Plain insulin, also known as unmodified or crystalline, is short-acting with an onset of 20 - 30 minutes and a duration of 6 - 8 hours.) Some time later Mr. Thomas was changed to protamine zinc insulin, 70 units daily. As the infection subsided the amount of insulin his body required decreased. On discharge he was receiving 45 units of PZI. His Clinitest and Acitest both remained negative.

The pain in Mr. Thomas' hip became almost unbearable at times. It was not relieved by acetophen compound with codeine gr. ½, so he was given Demerol 100 mg. q.3.h. p.r.n. (Demerol, or meperidine hydrochloride, resembles codeine in its analgesic qualities. It is not as potent a hypnotic as morphine.) It only partially relieved the pain.

Until the infection disappeared the diabetes was almost impossible to control. Mr. Thomas was given chloromycetin 500 mg. q.i.d. for five days. It had apparently done nothing to control the infection and was discontinued because the doctor felt that an antibiotic might prevent the abscess from "coming to a head." Six days later, the patient was given Signemycin 500 mg. q.i.d. (This is a broad-spectrum anti-microbial combination of oxytetracyline and oleandomycin.) After 11 days of administration his temperature returned to normal. Seven days later when it was discontinued his temperature remained normal.

Hot compresses did not relieve the pain, and although Mr. Thomas gained some relief while he was in a hot bath, the effort of getting in and out of his bed and the tub was exhausting. For this reason he refused the baths more often than he accepted them.

Nursing Care

Mr. Thomas had been a diabetic for quite a few years and knew a great deal about his condition. He was very aware of the importance of caring for his feet. Each day they were washed with warm soapy water, dried carefully and rubbed with cocoa butter.

Because of pain and a general feeling of malaise, it was sometimes impossible for Mr. Thomas to eat his meals. The missing calories were made up with juices. Sometimes he had to be coaxed to take them.

One afternoon he stated that he felt weak. His skin was grey and moist, he was drowsy and very apprehensive. His pulse was 120 and full. He was immediately given a glass of orange juice containing three teaspoonfuls of sugar. Insulin shock was prevented but this incident proved that although his Clinitest was + 4 it was possible for him to have an insulin reaction.

Mr. Thomas' blood sugar was high so it was necessary to watch for diabetic acidosis. Fortunately it did not occur.

During Mr. Thomas' hospitalization there was an influenza epidemic in the city. The hospital was closed to visitors, so he was very lonely for his wife and family. At times when his morale was very low, I made a point of staying near him to chat about his family.

Rehabilitation

Mr. Thomas needed no new teaching. The lessons he learned from the doctors and nurses by their actions and discussions with him served to reinforce his knowledge of the disease and to reassure him that he was caring for himself in the best way possible. The present illness emphasized for my patient and for me, the importance of the prevention of infections in the diabetic patient.

The Problem of Diabetic Control

The Patient as a Person

Mr. Henry, aged 43, had his own business as a plaster contractor. Six years ago he decided he would like to engage in some work where he could be of greater service to his fellowmen. Despite the fact he had had only grade X schooling, he enrolled in a two-year course in psychiatric nursing. Completing this preparation he has been employed as a psychiatric nurse up to the time of his present hospitalization.

Past History

Mr. Henry's diabetes had been diagnosed five years earlier when he was admitted to hospital for a hemorrhoidectomy. Twenty minutes prior to the operation a 2 + sugar was discovered. An immediate repeat urinalysis showed only a trace of sugar since the patient had had no breakfast. His fasting blood sugar was 180 mg. per cent, normal 80 - 120 mg. per cent. Despite these factors the operation was performed. His postoperative course was satisfactory.

Mr. Henry recalled that there had been an increase in his urinary volume and fluid intake in the past year. He had also noticed that he was more diaphoretic on less exertion. He was discharged on five units of crystalline insulin twice a day and a diabetic diet of 2000 calories. The doctor's objective was "to carry the patient on the minimum requirement of regular insulin and diet, with a view to discontinuing the insulin if possible." For the next two years there was little trouble controlling the disease due to the patient's intelligent care of himself. He read many books and articles on the subject of diabetes and, because of his training, thoroughly understood his condition.

Four years ago when he was admitted for dental surgery, the doctor decided to reassess Mr. Henry's diabetes.

On admission his fasting blood sugar was 188 mg. per cent. After breakfast it was 460 mg. per cent. Postoperatively he received crystalline insulin and intravenous glucose. During his hospital stay experimentation was made with isophane insulin (NPH) but this did not control the diabetes properly. He was discharged on a regulation dose of 45 units of protamine zinc insulin and a 2500-calorie diet. At this time his urine varied from a 3 + to 4 + Clinitest with a negative acetone.

Present Illness

Early last fall, Mr. Henry began to have trouble controlling his diabetes. He had his blood sugar tested once a week and the results were usually above normal. His diet had been increased to 2700 calories. His dosage of insulin was increased by 20 units so that he was receiving 65 units of PZI a day. He noticed that he was drinking excessive amounts of water. He kept a jug of water at his bedside at night because his mouth "began to feel like parchment." Because of the excessive fluid intake, he had abdominal cramps which increased in severity as the polydipsia became worse. A gastric analysis was done to rule out the possibility of an ulcer. The results showed that he had only a minute amount of gastric juice. He was given hydrochloric acid to take before each meal. At this time his Clinitests showed a positive reaction most of the time. He had made a practice of testing his urine three times a week when his diabetes was regulated, and three times a day if there were any positive Clinitests. Besides the 65 units of PZI once daily he took 5 units of crystalline for every 3 + Clinitest and 10 units for every 4 +. The severity of his diabetes increased until he was taking as much as 20 to 30 extra units of insulin a day. A month before his admission to hospital, Mr. Henry had two slight insulin reactions. His blood sugar was consistently high and he was having no negative Clinitests. It was in this condition that he was admitted.

He adjusted very quickly to the hospital routine and at the end of the first evening was chatting companionably with the other patients in the ward. Because the doctor had asked him to be up and about, he passed the time by walking around the ward and getting acquainted with the other patients. After two days, when he felt more "at home," he began helping with jobs around the ward. Towards the end of his hospital stay he was allowed to do the Clinitests for himself as well as for other diabetic patients.

On admission Mr. Henry's temperature was 98° F., his pulse was 72, regular and of good quality and his respirations were 20. Four hours later he had an insulin reaction for which orange juice was given with good effect.

An 1800-calorie diet was ordered. After having had a 2700-calorie diet it was learned that he was very hungry. He had been used to eating in the evenings at home so arrangements were made with the diet kitchen to provide him with evening nourishment.

The chest x-ray showed no evidence of a parenchymatous lesion but the hilar shadows and lung markings were heavy.

His fasting blood sugar was 346 mg. per cent on his first morning in hospital. From this initial high it gradually lowered until at the time of his discharge two weeks later it was down to 123 mg. per cent.

On the fourth day of hospitalization his insulin was increased to 20 units before every meal, three times a day. He was weighed and it was found that he had lost 17 pounds in three months. He had a slight insulin reaction for which two glasses of orange juice with added sugar were given with good effect. He described the symptoms of his reaction as a "tingling" feeling in the tips of his fingers, a "hollow sensation in his stomach" and diaphoresis. His Clinitests were still positive for sugar.

During his sixth hospital day, Mr. Henry experienced three reactions, one in the early afternoon, the second in the late afternoon and the third in the evening. He was given four ounces of orange juice and one teaspoon of sugar, each time. The patient was nervous, tense and unable to sleep in the early part of the evening. At midnight a sedative was given and he slept well.

Before breakfast the following morning the doctor was notified of the previous day's happenings. He decreased the insulin to 15 units before breakfast. Later it was reduced to 15 units before

dinner and supper with 20 units before breakfast. The diet was increased to 2100 calories, the extra calories to be divided between breakfast and supper. The patient had one more reaction. Mr. Henry stated that these reactions were much more severe than any he had had previously.

Two days later, the crystalline insulin was adjusted as follows: before breakfast 20 units; before lunch 15 units; before supper 10 units. Mr. Henry had two more slight reactions. On the ninth day his insulin was changed to 45 units of NPH once daily before breakfast. On the eleventh day, his diet was increased to 2300 calories. As the mid-afternoon and evening are the times during which reactions may occur when NPH is being used, the extra 200 calories were divided between dinner and the evening nourishment. His Clinitests were now negative almost every time and his blood sugar was 123 mg. per cent. The diabetes seemed to come under control once the patient was started on a course of NPH insulin.

He was instructed to continue with his 2300-calorie diet and 45 units of NPH insulin once daily at home.

Teaching

No specific teaching was required as the patient understood the problems of diabetics. Mr. Henry had mentioned that he had been having trouble with his eyes. He noticed that when reading for moderate lengths of time his vision had begun to blur. Because of the incidence of diabetic retinitis, it was suggested that he visit an ophthalmologist as soon as possible.

Summary

It can readily be seen from these two nursing care studies that the diabetic patient can lead a happy and productive life. Both patients had a good understanding of their condition and a positive attitude toward the disease despite frequent hospitalizations. They have learned to cope with an incurable disease and how to prevent complications. These studies may make helpful reading for the new diabetic who is frightened or the old diabetic who is discouraged.

Juvenile Diabetes

Sister Marie de St. Marc

A student nurse teaches a new diabetic about her disease and its control.

Yvonne, a girl of 17, came to hospital. The second oldest in a family of ten, she was orphaned at 14, and became the mother of the house.

One could notice the early maturity. Her flushed appearance and nervous gestures were indicative of extreme fatigue. Her temperature was 99° F, pulse 88, respirations 24, blood pressure 112/60 and weight 102 pounds.

She complained of symptoms which exactly characterize those of the diabetic: a sensation of hunger, excessive thirst, blurred vision, frequent large amounts of urine, loss of energy and weight, general malaise, etc. The details were carefully charted. After a careful examination, the doctor wrote emergency orders and asked to be called as soon as the reports came back.

After receiving the reports the doctor visited Yvonne again. He told her that she was diabetic, that she would have to be on a strict diet and take insulin injections. He told her that if she cooperated he would soon have the illness under control. She had nothing to worry about, the prognosis was excellent especially because she was an intelligent patient who would cooperate with her doctor. Before departing he asked the nurse to be responsible for teaching this young girl about her illness.

Sister Marie de St. Marc was a student at the Hôtel Dieu Hospital in Montreal when this paper was written.

Doctor's orders:

Blood sugar daily
Save all urine
Clinitest q.i.d.
Acitest q.i.d.
Measured diet
Crystalline insulin before meals as follows:

sugar in urine	*insulin*
2 +	16 units
1½ +	8 units
1 +	6 units
½-¾+	4 units

N.P.H. insulin 10 units every morning.

N.P.H. insulin has an onset of action of two hours and duration of 18-24 hours. It aids greatly in the control of diabetes.

The next day before lunch, Yvonne had a visit from her family. I noticed that they brought her a lovely box of chocolates. A difficult battle was being waged within the patient. A conflict arose between her desire to satisfy her tastes and her desire to control her diabetes. She told herself it was hopeless to have to follow a diet all her life. I explained to her that diabetes in itself was not serious but that there are complications. I explained them to her as simply as possible. Nothing more was necessary to convince my patient that she must, at all costs, be faithful to the insulin and the diet.

The patient learned that diabetes is due to an insufficiency of the secretion of insulin from the pancreas. This insufficiency causes metabolic disturbances. Too much sugar is liberated from the liver and so it appears in the urine.

Further education of the patient included teaching her how to use Clinitest. The method employed is:

mix five drops of urine and ten drops of water in a test tube. A Clinitest tablet is then added and you wait until the boiling has ceased. The color is then compared to the color chart and insulin given according to the results. The Acitest is even more simple. A bit of powder, about the size of a pea, is put on a piece of white paper and two drops of urine are added to it with an eye dropper. With the help of a color chart the presence or lack of acetone can be determined.

Soon, Yvonne was able to carry out her tests without supervision. The 24-hour specimen permitted determination of total output and the total amount of sugar during the same time. The blood sugar determines the level of sugar in the blood. Acetone indicates the presence of toxic acids. Insulin controls the blood sugar.

As the days passed, this young girl became the object of frequent and attentive visits by her doctor, in whom she placed complete confidence. She had faith in his orders and with the cooperation of her nurse carried them out to the letter.

During the first few days there was little change in the tests. After five days there was marked improvement in her health, a drop in her blood sugar and the quantity of sugar in her urine. In two weeks the diabetes was under control. The doctor told her that she could be discharged as soon as she could give her own injections. That was all she needed to make her decision. All that remained to do was to teach her to prepare her injections of insulin.

I explained how the syringe was marked . . . 40 units and 80 units. I emphasized the importance of checking the concentration on the bottle and using the corresponding scale on the syringe. Sterilize the top of the bottle with alcohol. Draw into the syringue the same amount of air as the insulin prescribed. Shake the bottle then force the air from the syringe into it. Withdraw the number of units required, checking again carefully. Clean the skin on the arm or the anterior surface of the thigh with alcohol, being careful not to inject it too closely to former sites.

The patient was soon able to give herself injections with ease. She learned to sterilize the syringe by boiling it for ten minutes, then wrapping it in a sterile wrapper.

I advised my patient to take extreme care of the skin of her feet, to take a warm bath daily and to dry well between her toes; to be careful not to cut her toe nails too short; never to touch corns, and to prevent them by wearing shoes that are not too tight; to avoid injuries, and treat them immediately they occur; above all, never to forget to take her insulin.

The doctor gave Yvonne a diabetic

identification card with instructions always to carry it. It read as follows:

> I am a diabetic and take insulin. If anyone finds me ill, unconscious or behaving in a strange manner, put a cube of sugar or a candy between my teeth or make me drink a glass of orange juice slowly. If, within 15 minutes I am not better, take me to the nearest hospital or notify my doctor.
>
> My name is ..... Tel. .....
> Address .....
> My doctor is .....
> Address ..... Tel. ....

She was also given a diet sheet. It bears repeating: "The diabetic who accepts and understands has already overcome half of the problem. With diabetes, a grain of wisdom is worth the treasure, health."

You Are What You Eat

DOROTHY COMEAU

Have you a low threshold of fatigue? Do you have problems with your budget? Try examining your physical fitness and your food dollar against the criteria that follow.

MALNUTRITION is the condition brought about by the improper assimilation of food. Without food, our very life could not be sustained and without *good* food and a sound diet physical fitness cannot be attained.

> The difference between what you are and what you would like to be may largely be a matter of the kinds of food you are eating. Foods are body-building materials and the kind of body one has depends mainly on the kind of food eaten.[1]

One needs not only sufficient food, but a varied diet, because there are some nutrients which require the presence of others in order to be fully used, in somewhat the same way as chemical reactions require catalysts.

The amount of food required for an average day's work, in terms of calories, ranges from 2800 in the colder countries such as Norway, down to 2200 in warmer countries such as the Philippines. In the five years preceding World War II, about 38 per cent of the world's population had to subsist on less than 2200 calories per day. In the past twenty years this has risen to 59.5 per cent; in other words, "almost three people out of every five in the world today are hungry."[2] This is partly due to the fact that only 8 per cent of the earth is under cultivation — 8 per cent of the world's surface in crops to feed two and one half billion people! Even more startling is the fact that "one-third of mankind consumes three-fourths of the world's food."

Miss Comeau is a student in the degree program, X-ray Technology, of Mount Saint Vincent College, Halifax, N.S.

Causes of Malnutrition

> In spite of all the efforts of international organizations . . . in spite of increased production, food supplies are just keeping pace with the growing population . . . Even in countries where calorie levels are adequate, diets do not contain enough protective foods . . . To combat the inequality in the world's food supplies the Food and Agriculture Organization (of United Nations), in 1943, established food consumption targets representing food supplies which, from the nutritional standpoint, are quantitatively and qualitatively adequate for everybody . . . The production of cereals would have to be increased by 50 per cent, the production of meats by 90 per cent, of milk and dairy products by 125 per cent, vegetable oils 125 per cent, fruits and vegetables 300 per cent.[1]

We in Canada have an abundant food supply, being one of the ten

countries having the highest calorie level in the world. Nevertheless, evidence of malnutrition exists among both rich and poor. In some cities where dietary studies have been made, it has been estimated that one-fifth of the families are not getting the right kind of food or the right amount.

> In 1955, 86 Canadians died of malnutrition due to vitamin deficiencies. Three of these died of scurvy, two of beri-beri, five of rickets, four of osteomalacia and 72 of other B and C deficiencies. Yet, in 1945, only 44 deaths from malnutrition were reported, even after six years of war. And in 1935, there were 72 deaths. All these deaths are, of course, totally unnecessary, but after all, they are not so many in a population of 16 million. Far more important are the many thousands of Canadians suffering from debilitating forms of malnutrition.[2]

According to a nutrition survey covering all age groups in 14 different areas of Canada, made over a 10-year period, 14% of the people were anemic due to lack of iron, protein and various vitamins; 7% had rickets; 10% had sore itchy eyes, sore lips and sore tongue due to a lack of milk products, liver, meat and eggs; 3% had night blindness, poor skin and lowered resistance due to lack of vitamin A; 16% had protein deficiency from lack of sufficient meat, milk, fish; 3% of males and 4% of females were 10% underweight; 1% of males and 2.5% females were 10% or more overweight; 0.2% lacked niacin (vitamin B) which is found in potatoes, cereals and meats; these showed digestive disturbances, skin eruptions, mental depression and pellagra. "Apart from these people who show well defined results of nutritional deficiencies, 12 to 50 per cent of Canadians surveyed were endangering their health through eating much less than the amounts of protective foods recommended in Canada's Food Rules."

All surveys in every area have shown that some people do not make use of the foods available. The problems most frequently encountered were:

> insufficient use of vitamin D by school children; inadequate use of milk for calcium and riboflavin; low intake of fruits and vegetables as sources of vitamin C; over-use of sweet foods and fats which destroy appetite for more nutritious foods.

Three main factors govern eating habits: intellectual, psychological and economic. Since Canada has an excellent food supply available, and most families have a reasonable income, supplemented by Family Allowance, faults in Canadian's eating habits do not seem to be due to an economic factor, at least in the majority of cases. In spite of the many opportunities for adult education, people are still quite ignorant of the relative values of different foods, proper selection and preparation of foods, not only to retain their vitamin values but to present them in an appetizing form. How many vegetables are cooked too long, and their juices poured down the drain! Another form of ignorance is the belief in fads and fallacies, for example, "skipping breakfast helps you reduce," "only babies need cod liver oil," "potatoes are fattening."

Psychological factors, attitudes towards food, can cause anything from constant nibbling to complete rejection of food. Teenagers congregate at the soda fountain in search of companionship; dissatisfied persons sometimes use food as a substitute for other objects that they crave; hard-working businessmen may be too fatigued at mealtime to eat properly. Ethnic groups who are accustomed to certain foods in their native lands may not find dishes to their liking here, and fail to supply the deficiency from the foods that are plentiful. Finally, there are the timid folk who will not try anything new, and the people who "eat solely to maintain life" and are not interested in food. A balanced personality shows here as in all aspects of life — one's attitudes towards food may be quite revealing.

The economic factor regarding foods in Canada seems to be compounded of ignorance and attitudes. A good many people spend money on soft drinks, candy and other fancy items, so-called "empty calories"; or they buy the most expensive cuts of meat when they could, with skill and training, make the cheaper cuts equally appetizing. Nutritious and appetizing food for Canadians is well within the average budget. The trouble is that so many fail to see that "ounce for

ounce, milk is cheaper than soft drinks raisins cheaper than chocolate bars, peanut butter cheaper than jam"[1] and that there are countless exchanges or substitutions that can be made in menus and recipes that will preserve or even increase their food value while decreasing the cost of a meal.

Better nutrition can come only when people are interested in knowing how to get the best possible diet for what they have to spend. In most areas there are agencies of one kind or another capable of providing such information, for example, the extension services of universities and colleges, public health and nutrition clinics, child welfare and health centers. Safeguarding our food supply and keeping the food costs within the purchasing power of the low-income groups should be a part of our national defense program, in the building of a healthy nation.

Nutrition is necessarily one of our major life-time pre-occupations. What we eat will either contribute to our life's happiness and effectiveness or will condemn us to live below our potential in both health and enjoyment.

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The Profession and the University

Edith M. McDowell, M.A.

Canada's first Master's degree course in nursing has been launched.

During the next decade, an increasing number of Canadian university schools of nursing will offer advanced educational programs. For many years, the Canadian Nurses' Association and many individual nurses as well as non-nurses, have been asking why our university schools of nursing did not offer post-baccalaureate degrees. Our American colleagues, to whom we are so much indebted, have asked the same question.

This year, for the first time, two post-baccalaureate students are registered at the University of Western Ontario School of Nursing. They plan to complete the academic requirements of a two-year program leading to a Master's degree in nursing. This program is one of the projects made possible by the W. K. Kellogg Foundation's five-year grant to the school of nursing. In the early development of this program, the school proposes to focus attention upon the field of administration, particularly administration of nursing services.

The process of defining the content of advanced educational programs is not without its problems. One difficulty arises within the universities where nursing is a comparative new-

Miss McDowell is dean of the School of Nursing, University of Western Ontario, London, Ontario.



Edith M. McDowell

comer. The faculties of the liberal arts, of law, medicine and theology have all had a very much older association. Historically, many universities had their origins in the development of one or other of these faculties. Programs of nursing education did not make their appearance in Canadian universities until 1920. The selection and sequence of educational content of all programs, the academic standards to be maintained, the degrees to be conferred are subject to approval by university senates. Faculties of Schools of Nursing have to face these questions:

> Does nursing have its own content? What is this content?
>
> How should the content be selected and in what sequence should it be given to meet senate requirements at the Baccalaureate, Master and Doctoral levels of academic achievement?

The difficulties in planning university curricula are not lightened by the conflicting views of our profession concerning the art of nursing. Inconsistencies exist between our definition of the nature of that art and our active practice of it. Do we not have the degree of freedom that a profession requires in order to bring our aspirations into closer alignment with our practice? Does the failure lie in our educational programs or are administrative patterns in the practice field such that many nurses are frustrated in their attempts to apply the art of nursing as they believe it should be applied?

An analysis of the formulations concerning the nature of nursing in order to discover implications for education and practice, reveals that nursing is a synthesis. The content is derived from many fields of study that fall mainly into three categories:

1. spiritual studies
2. humanistic studies
3. the natural philosophies, that is, the sciences.

Take away any one of the three and the art of nursing is impoverished and incomplete, both in its education and practice.

That we have been concerned with the nursing situation is evidenced by the frequency with which certain phrases have grown into our professional literature in recent years:

> the nurse never nurses less than the whole patient . . . . (Surely a blinding flash of the obvious!)
>
> comprehensive nursing care . . . total care needs . . .
>
> patients as people . . . interpersonal relationships in nursing . . . the person in the body . . . nurse-patient relationships . . . the nurse does not nurse pathology . . . she works with people — and a host of others.

If these expressions represent what is so obvious to us in the practice of nursing, is it possible that our current need to use them is symptomatic of some deeper lying pathology? Concerning man's spiritual needs in our society, there is not a little confusion and great questing for certitude. Between the humanistic studies and the natural sciences, there is a wide chasm across which human voices cannot be heard clearly. If we were to chart what appears to be a "pecking" order, the natural sciences would seem to have leadership prestige. This state of affairs creates many difficulties to all of the helping professions.

The difficulties presented thus far make their impact upon our progress in planning for advanced educational content. These difficulties could be very challenging to the nursing profession and are insurmountable only to a profession that does not attempt to see its situation clearly. Of the more than 60,000 practising nurses in Canada, how many are making an effort to see our professional situation clearly? How many of these cut short their own general education in order to enter hospital schools? How many of these closed their professional education with the attainment of nurse registration? Do they realize that through their practice the general public (and this includes other professional groups) derives the materials from which it builds the nurse-image in our society? Need we be surprised that the public appears bewildered when we use the expression "nurse education" but seems to understand us only too well when we speak of "nurse training"?

The nursing profession constitutes the largest single group of health workers throughout the world. Our immediate concern as a profession is with the health of the people of Canada. For too long a time we have per-

mitted public attention to focus on *numbers* and *quantity,* rather than on *quality* of health work.

If our basic education is too narrowly technical;

if we stress the natural sciences and exclude spiritual and humanistic understandings;

if the art of nursing is not practised at a high level in the patient care field where the student learns;

if we do not have well prepared teachers and administrators;

if administrative practices at all levels of responsibility are outmoded

then the quality of health care for the people of Canada is threatened.

As they have since 1920, employing agencies will turn increasingly to university schools of nursing for specially prepared nurses to fill positions of teaching, supervision, public health nursing and all levels of administrative responsibility. With the continuing expansion of health services, the demand will continue. Notwithstanding our attempts to increase undergraduate enrolment and the numbers of auxiliary workers, it should not be difficult to see that an increase in the numbers of students and of auxiliary workers, as well as the constant coming and going of general staff nurses will continue to strain our administrative and supervisory resources. This is the point at which our professional burden is most serious and difficult.

Is there any way in which we can help a larger percentage of our membership to accept the need for more advanced educational preparation in order to assist with the heavy burdens now carried by women in all leadership positions within our health agencies? What we are able to accomplish through university programs is contingent upon the levels of professional aspiration entertained by our practising members.

Shortages: Nurses or Nursing?

MARGUERITE KAKOSH, Ph.D.

What kind of nursing are we practicing in our hospitals today? When we think about it, that is, about ourselves, are we satisfied with what we see, hear, feel and do?

IT IS CONSTANTLY asserted that there is a shortage of nurses. The administrator cannot find enough and if he could his budget could not stand the strain. The doctor would like more nurses. The patient would like more professional nursing care. One study in the United States showed that patients received only 18 minutes of professional nursing care in an eight-hour period. It is apparent that the more education the nurse has, the higher her salary becomes and the further she moves from the bedside. The director of nursing service wants safe and adequate nursing care. She has by far the largest budget in the hospital. How much nursing care does the nursing service dollar buy? Where is the rest going? And the nurse, she is the unhappiest of all! She wants to spend more time with patients. She feels that "her duties are calculated to keep her from the bedside."

Fundamentally we want to nurse. If we had all the time we wanted would we be there at the bedside? Would the care be of a different character or quality or would it be the same? If we wanted to and if we had unity of purpose, we could learn to nurse *differently.*

Dr. Kakosh, who is an associate professor at the College of Nursing of Rutgers University, New Jersey, gave this address at the annual meeting of the Association of Nurses of the Province of Quebec.

The Practising Nurse

Systematic study of the *actual practice* of the professional worker is neces-

sary to secure improvement. The profession has not done this, neither have schools of nursing. What changes that have come about have come through nursing education. If one looks at the history of graduate programs it is evident that their educational objective has not been *practice*. It is regrettable that there are so few opportunities for the preparation of specialists in nursing *practice*. Can a nurse really teach if she has not had on an advanced level the course content she is going to teach?

Patient care has not had true professional quality. There are only elements of professionalism in it. Why? First, there is limited supervision in clinical areas on completion of the basic course. Second, there is little or no opportunity for the student or graduate to observe professional nursing care. The supervisor and head nurse must be able to practice above the level we now have in the basic course. There is a direct correlation between the quality of care which will be given and that which a supervisor is herself able to practice.

Actual nursing care of patients counts so little in remuneration, status, prestige etc. Bedside care seems so much less important than the work of the head nurse or supervisor. "I'm just a staff nurse" is a common remark. "Today I was an aide. I did all the work that an aide does — gave baths, dressed and fed patients, assisted them into wheelchair . . ." Was there really any difference in the practice of the aide and the nurse? Perhaps there is little reason to value it any more highly. Well-prepared skillful practitioners are paid the same as any who have put on a uniform for the first time. Until we are *able* and *enabled* to practice that quality of care that has inherent in it a growing source of satisfaction, we cannot expect respect for it.

Do we know *what* we are educating nurses for? Is my care the same as that given by the auxiliary? If there is no difference then the *profession* of nursing will die and only the *occupation* of nursing will continue to exist!

What difference will the quality of the care make? Will it make a difference?

Short term curative care is typical of what is commonly given in our hospitals today. It is *hospital-routine* and *procedure* centered. The nurse is kindly, well-intentioned and efficient; she approaches the nursing problem in terms of getting the *work done*. This care is considered to be of good quality by present standards.

A "gooder" type of care is possible — long term and rehabilitative. The nurse makes the *patient* the central focus. She brings to the nursing problem a deeper understanding of the roles of science; social and psychological, as well as physical and biological. This type of nursing does not imply a different definition but a broader application. The meshing of these sciences gives an increased depth and penetration of meaning to the practice of nursing. There is an understanding of the human being in order to help *him* to plan *his* way of carrying out treatment at *his* rate of growth, and to fit into *his* way of living.

This type of *practice* depends on the nurse's understanding and use of herself. Each nurse selects only those things which have meaning for her. To the extent that we can accept these concepts we will effect change — change in nurse practitioners.

> When one is a stranger to oneself then one is estranged from others too. If one is out of touch with oneself, then one cannot touch others.
>
> — ANNE LINDBERGH

Bibliography on Cancer for Nurses, U.S. Public Health Service Publication, No. 687, has just been released. It includes lists of books, pamphlets, annotated audiovisual materials, teaching aids, such as prosthetic devices and other equipment for care of cancer patients and annotated references on cancer of specific sites and nursing aspects of cancer. Available from: Superintendent of Documents, Government Printing Office, Washington, D.C., at 20 cents per copy.

* * *

The constant interchange of those thousand little courtesies which imperceptibly sweeten life, has a happy effect upon the features, and spreads a mellow evening charm over the wrinkles of old age.

— WASHINGTON IRVING



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Seminar on Learning

An international seminar on "Learning to Investigate Nursing Problems" is being held in Delhi, India, this month. Thirty nurses from 15 countries will attend. The staff of the Florence Nightingale Education Division of ICN is organizing this seminar which will be financed by income from the Trust Fund of the Florence Nightingale International Foundation, supplemented by a grant from the Rockefeller Foundation.

During the last ten years nurses have, either by themselves or with other professional people, made great strides in systematic studies and scientific investigations of nursing problems. The experience gained will be drawn upon to help participants in the seminar to select those nursing problems which should be solved through research and those which can be solved by other measures. There will be both lectures and group work during the seminar. For the latter, small groups will work intensively on specific problems chosen by the participants themselves, so that the experience they gain will be highly relevant to their own current nursing problems.

Among problems which may be studied are: methods of ensuring the continuity in the community of the patient's nursing care after discharge from hospital; and how research on this subject can be assisted through home visits. Various research techniques will be studied as well as how the methods used in the social sciences can be adapted to nursing research.

Dr. CLARA HARDIN, sociologist and anthropologist and executive director, American Nurses' Foundation is chief consultant for this seminar. Assisting will be Dr. RENA BOYLE, chief, Nursing Research and Consultation Branch, Division of Nursing Resources, Public Health Services, USA Department of Health, Education and Welfare, and Professor J. H. F. BROTHERSTON, Usher Institute, Edinburgh, Scotland, representing the public health field.

National Office Staff

Miss JUSTINE DELMOTTE joined the staff of National Office December 7, 1959, as assistant to the general secretary. Miss Delmotte is secretary of the Public Relations Committee besides assisting in the overall administration of National Office. Her broad experience in nursing — both hospital and public health and her fluency in four languages, will enable her to play an important part in CNA work. She is warmly welcomed by us all.

Emergency Health Services Conference

On November 16-18, 1959, the President represented the Association at this national conference. Miss Helen Mussallem, representing nursing education and the General Secretary also attended as members of the Defence Medical Dental Services Advisory Board.

This conference brought together representatives of government and voluntary organizations who are concerned with problems involved in Emergency Health Services.

One hundred and five persons attended this meeting — a Minister of Health, Deputy Ministers, nurses, physicians, medical officers, armed service personnel, dentists and representatives of Canadian Medical, Canadian Hospital, Canadian Nurses, Red Cross, St. John's Ambulance Associations.

The main theme of the conference was coordination of services. Emphasis was also placed on "Self Help."

A cabinet committee has been set up and is the ultimate authority. A new committee has been established called Emergency Measures Organization—"EMO." The secretary of EMO is a member of the cabinet committee. EMO has two branches — one for emergency government services, the other, public services.

The Armed Services will be assigned certain activities but by no means the entire program.

A mass education program on a national basis is being planned. The objective is to have each individual informed, prepared to take care of himself and fit into the total program in the event of an emergency.

The President of CNA, speaking on television at the conference, said:

> Members of the CNA have always supported programs to improve the health and welfare of Canadian citizens. They will not lag behind in this regard.

The Order of St. John of Jerusalem

In October, the General Secretary was appointed to the Priory-Council of the Order of St. John of Jerusalem and represented the CNA at the meeting of the Grand Priory held in Ottawa, October 22. In conjunction with this, the General Secretary, as CNA representative, attended an Investiture at Government House, when Miss Evelyn Pepper, RRC and Lieutenant Commander Mary Nesbitt, were made Serving Sisters of the Priory of Canada of the Most Venerable Order of the Hospital of St. John of Jerusalem.

International Visitor

Mrs. Marguerite Mendes-Hamilton of Ministry of Health, Kingston, Jamaica, has been awarded a WHO scholarship for three months' study in United States and Canada.

Mrs. Mendes-Hamilton holds the position of public health nursing supervisor for South Eastern Jamaica. Plans are forging ahead in Jamaica's Ministry of Health for the integration of public health, hospital and clinical services. It is in preparation for the implementation of these plans that Mrs. Mendes-Hamilton is visiting the provinces of Eastern Canada this month. The CNA extends a welcome to one of Jamaica's nurse leaders.

Film Preview

A new film in color entitled "Hospital Sepsis — a Communicable Disease" produced under the supervision of Dr. Carl W. Walter by Johnson & Johnson Limited was screened in Ottawa through the courtesy of the National Film Board.

It clearly describes the hazards involved in spreading infection through routine hospital procedures, and suggests methods of control. This film is recommended not only for professional personnel, but for all those involved with hospital housekeeping and maintenance of the hospital plant.

Curriculum Workshop

Forty-seven Canadian nurse educators registered at the Curriculum Workshop held in Ottawa, November 23-25, 1959, and organized by the CNA Committee on Nursing Education. This workshop was a preliminary step towards the preparation of a National Guide for Curriculum Development. Miss Florence Elliott, director, Study on Cost of Nursing Education, National League for Nursing, formerly director of Curriculum Conference Project, National League for Nursing, was coordinator and consultant. Through formal lectures, informal discussions and group work concepts of nursing and their implications in the development of a curriculum were discussed.

National Committee Meetings

CNA National Committees on Nursing Service and Nursing Education held their annual meetings in Ottawa in November 1959. Topics discussed at the meeting of the Committee on Nursing Service were job satisfaction, turnover of staff and social needs of nurses; home care plans and implications for nursing in hospital insurance plans. A draft copy of a "Guide for Head Nurses in Hospitals" was reviewed. This guide will be presented to the Executive Committee for approval this month. **Please watch this column for notification of its publication.**

Discussion during the meeting of

the Committee on Nursing Education centered around the educational programs for the registered nurse and the assistant nurse; philosophy, aims and objectives of basic nursing education diploma programs and the establishment of Canadian criteria for the evaluation of schools of nursing in Canada. The report of the Curriculum Workshop was discussed and further plans were made toward the development of a national curriculum guide.

Convention Personality

The preparations required for a General Meeting of the Canadian Nurses' Association involve a staggering amount of work for the nurses of the hostess province and city.



DOROTHY GILL

A sudden, even if very temporary rise in population within the convention city amounting to hundreds of people calls for months of planning if they are to be fed and housed comfortably. Auditorium space must be found; various social and recreational activities must be planned to provide a welcome break in a busy week; provision must be made for welcoming delegates and directing them on their way as each bus, train or plane arrival brings its complement of visitors. These and a horde of other details, down to providing information about the best place to get a fresh "hair-do," come within the scope of the Arrangements Committee.

The chairman of this committee requires, among other qualities, efficiency, endurance, and a sense of humor. **Dorothy Rosamond Gill** fulfills these requirements admirably. A graduate of Victoria General Hospital, Halifax with postgraduate preparation in teaching and supervision from the School for Graduate Nurses, McGill University and in psychiatric nursing from the University of Toronto, Miss Gill is supervisor in psychiatric nursing at V.G.H. She has taken a very active part in the work of professional organizations as president of her alumnae association; secretary and president of the Halifax Branch, RNANS; recording secretary and member of the public relations and nominating committees, RNANS. She can be counted upon to give the most capable leadership possible in helping to make this one of the best conventions ever.

New Diploma Course

The School of Nursing, Dalhousie University, Halifax has announced the establishment of a new diploma course in nursing service administration for head nurses, supervisors, and junior administrators in hospitals and public health agencies.

This is a general course extending over a period of approximately nine months. Only nurses who have had at least two years of graduate professional experience in a junior executive position will be admitted. The approximate cost will be $350.

Further information may be obtained from Miss E. A. Electa MacLennan, Director.

Nursing Profiles

We are pleased to extend special greetings this month to **Justine Marie-Rose Delmotte** who has joined the staff of National Office as assistant to the General Secretary. Born in the United States, and educated in Nova Scotia, Miss Delmotte is a graduate of the Royal Victoria Hospital, Montreal, with postgraduate education in public health nursing at the School for Graduate Nurses, McGill University, Montreal.



(Paul Horsdal)

JUSTINE DELMOTTE

She has had extensive experience in nursing on an international level beginning with her wartime service, 1942-45, as Captain (N/S) in the South African Military Nursing Service in Africa and Italy. In 1945 she joined UNRRA and IRO, working as an area nurse and then as a zone nurse in Germany and Austria. In 1948 she returned to Canada for a year of postgraduate study and subsequently joined the City Health Department of Montreal for a brief period. In 1950 the lure of faraway places resulted in an appointment with the World Health Organization and led to successive duty periods in Thailand, Cambodia and Morocco. Miss Delmotte returned to Canada again in 1958 and prior to her present appointment was a nursing counsellor with the Department of National Health and Welfare, Civil Service Health Division.

Fluent in four languages and with her rich background of nursing experience, Miss Delmotte will have much to contribute in her new position. Nurses are moving about from country to country in increasing numbers and with a freedom unknown just a few years ago. National Office is called upon to arrange for study tours and official visits for a growing number of overseas visitors each year. Apart from this group are the girls who seek employment in our hospitals and who bring with them problems in relation to registration and professional preparation. Her colleagues in National Office and the staffs of our provincial associations will welcome the expert advice and guidance that Miss Delmotte can undoubtedly offer. Canadian nurses can well be proud of the fact that one of their members has contributed so much to international nursing, and pleased that her skill and experience have been placed at the service of our own national association.

A little over a year ago **Emily R. Groenewald** left Montreal to take up her duties as assistant director of nursing at the DVA Hospital, Lancaster, New Brunswick. Recently she was appointed director of nursing there.

Miss Groenewald received her preliminary education in South Africa. She is a graduate



EMILY R. GROENEWALD

of Women's College Hospital, Toronto and received her diploma in teaching and supervision at McGill School for Graduate Nurses, Montreal.

Much of her professional career has been devoted to nursing education — as an instructor, Guelph General Hospital; medical supervisor, Children's Memorial Hospital (now Montreal Children's Hospital); nursing arts instructor, Winnipeg General Hospital; educational assistant, DVA Hospital, Ste. Anne de Bellevue, P.Q.; and director, Montreal Central School for Nursing Assistants, Queen Mary Veteran's Hospital, Montreal.

Miss Groenewald has been active in professional associations throughout her career. She is an enthusiastic follower of Montreal "Alouettes" and "Les Canadiens" and enjoys music, reading, travel and the theatre.



(L. Ford)

LENORE DUGGAN

Lenore Duggan who has been appointed professor of health education at St. Joseph's Teachers' College, Montreal, is the first nurse in the province of Quebec to hold such a position.

A graduate of St. Mary's Hospital, Montreal in 1949, Miss Duggan engaged in postgraduate study at the School for Graduate Nurses, McGill University, specializing in teaching and supervision in medical and surgical nursing. In 1958 she was appointed assistant director of her school of nursing.

We extend our good wishes and congratulations to her in this new venture.



ISABEL T. COLVIN

Isabel T. Colvin has been appointed associate director of nursing service at Regina General Hospital where she has served for the past several years as assistant night supervisor 1950-52 and obstetrical supervisor 1953-59. Since her graduation from R.G.H. in 1950, Miss Colvin has also completed requirements for her Bachelor of Nursing degree from the School for Graduate Nurses, McGill University. She has taken an active interest in the affairs of her provincial association and has served as secretary of the Regina chapter and as chairman of the Committee on Nursing Service.

Expendable plastic oxygen masks, designed to provide maximum patient comfort, are now made of a special non-toxic green vinyl that gently conforms to the face. They remain soft and pliable in use, and can be trimmed with shears to conform to unusual facial features. The masks are used with standard oxygen connecting tubes or with large-bore tubing, and are sold with breathing bags for high concentrations of oxygen.

For further information write to: National Cylinder Gas Division, Chemetron Corporation, Chicago.

* * *

Medicine, the only profession that labors incessantly to destroy the reason for its own existence. —JAMES BRYCE

Manitoba Women's Hospital Auxiliaries Association

CHRISTINA MACLEOD

Hospitals serve the community but in Manitoba it is a two-way process. The zeal and hard work of women in their "leisure" time can contribute in large measure to the health of a community.

THE above title is quite a mouthful. It is also quite a handful to direct its workings in these days. This provincial association came into being on November 1, 1946. Aids had functioned, more or less, for 60 years wherever hospitals were established though they were few and far apart. In 1941 Dr. Buck of the American Public Health Association was requested to make a survey of provincial health needs. He made recommendations to the Manitoba Welfare Supervisory Board regarding the need for more hospitals and an increased bed capacity. Since that time hospitals have mushroomed all over the province.

The Hon. Paul Martin, former Minister of Health of the federal government, said:

> We are on the threshold of a new conception of hospital care. An administrative course is now being worked out by a Canadian Hospital Council Committee for a larger field of work throughout Canada and auxiliaries will enter into the picture more than ever before.

He was speaking at an organizational meeting of the National Council of Hospital Auxiliaries of Canada in Ottawa on May 29, 1951. The "larger field of work" was the increased numbers of hospitals mentioned previously.

A women's auxiliary is important to a hospital because the women of a community can do many things for a hospital that no one else can do. It is a truism to say that a hospital can not achieve its aims unless the public understands those aims and the means by which they may be accomplished. Unless it has the esteem and the support of the citizens of the community, the hospital can not function adequately. No matter what the population of your city, town or village or the total membership of your auxiliary, the members of the latter will exert an influence in proportion to their number, their enthusiasm and their intelligent appreciation of the hospital's problems. It is also a truism that the auxiliary member or volunteer who is well-versed in the activities of her hospital can tell its story better than the paid employee. To sell the hospital story takes ingenuity, energy and a deeply grounded belief in the value of the work. It also requires leadership.

The auxiliary's leaders have the duty of helping a group of community women choose activities and problems that are within the power and resources of the organization to pursue effectively. The group needs to feel that what it does is significant enough, important enough, difficult enough and necessary enough to challenge its thinking, talents and effort. Moreover the group must be able to make progress in its action, to carry out its program and reach its goals in an effective and controlled manner. It must feel and know that it is needed and fully appreciated.

Confidential information about individual members of a group belongs only to the members and their leaders. Personal information should be used only to assist in the leadership role and should never be released for common gossip.

The following excerpt is from an

Miss Macleod formerly a director of nursing of Brandon General Hospital, is the president of the Manitoba Women's Auxiliaries Association. In preparing this article the author drew some of her material from the auxiliaries suggested reference list.

address given by Mr. G. R. Rosenfeld, administrator of the Victoria General Hospital, Winnipeg. He was discussing the continuing and increasing need for auxiliaries.

> The humanitarian aspects of the care of the sick and injured in the hospital is the guiding principle which has served as a beacon to the women's hospital auxiliaries throughout the province of Manitoba and the world. It has not flickered or faltered, nor has the color changed. The money raised by the women's auxiliaries has done much to assist in the purchase of equipment and supplies for the care of the sick and injured. The public relations established through an informed and understanding women's auxiliary is the soundest foundation for a good hospital-community relationship. This serves to guarantee hospital financial security and permits the auxiliaries, through their volunteer services and fund-raising activities, to elevate the level of hospital care in the province of Manitoba. Hospitals can be understood best by and explained to the community most effectively through women's auxiliaries.

Public relations are discussed so much nowadays that we forget that each one of us is responsible for them every day. *What* we do or say or *where* we do or say it makes the difference between good and bad relationships. Let us ever be watchful in this respect.

From the beginning our provincial motto has been "Know your Hospital." The auxiliaries are proud of their hospitals. They want them to live and prosper. Judge Milton George of Morden, Manitoba, who is steeped in hospital work and recognized as an authority well beyond his native community said this of auxiliaries: "Voluntary women workers have kept hospitals from closing, particularly during the stressful years of the late thirties." He was living in a dried-out area of the province at that time and knew the situation well. "Those women who caught the vision and passed it on made an enduring contribution to those who are following in their steps." There was no director of volunteers then — it was really not feasible in eight-bed hospitals!

When visiting auxiliaries, guilds and aids throughout the province, one is struck with the perseverance it takes to keep on creating new projects. There



St. Agnes Guild Shop

must be careful planning to avoid duplication and to select proper launching times. As an example of a novel idea, one of the province's newspapers recently ran this headline: "Pilot Mound Bachelors are *Taxed* to Get Hospital a Sewing Machine." The women are continually coming up with new "gimmicks" and stimulating healthy competition. Often these are most amusing and unusual.



(Bill Rose)
The Volunteer and the Patient

Many of the women who make up the auxiliaries are grandmothers — but such youthful ones! Often they have had years of experience in church activities before turning their talents to hospital work. This places wonderful human resources for new direction and leadership at the disposal of the organization. The efforts of these women in public relations result in a well-informed community.

At the moment there are 73 auxiliaries in the province of Manitoba with more to be organized. Their value cannot be measured in dollars and cents. They have played their part in hospital building projects, preparing linens and obtaining necessary equipment for new units. They have assisted in student recruitment, arranged for loans for prospective nursing students. Their support has been given to local cancer campaigns, to the Red Cross home nursing courses designed to help relieve shortage of nursing service. Their achievements have really been too numerous to mention.

The following description of the work of the auxiliaries in four of our hospitals will serve to emphasize the importance of their role:

During the past five years, voluntary services provided to one of our large general hospitals — the Winnipeg General Hospital — by the White Cross Guild have totalled 70,025 hours. This would have an economic value of approximately $52,500. In addition the Guild provided the hospital with cash gifts amounting to $26,866. At present, their resources are being directed towards research work.

The guilds that serve The Children's Hospital of Winnipeg have raised an average of $25,000 per year during the past five years. In 1957 when the hospital residence was nearing completion, the six organizations undertook to provide the funds required for furnishing it. A total amount of $41,000 was acquired for this purpose. Now their resources are being directed to research.



Arranging flowers

The Princess Elizabeth Hospital Guild serves three hospitals for the chronically ill — the Princess Elizabeth, the King George and the King Edward. The Guild had pledged itself to provide the patients with friendship, comfort for body and mind, and to assist the hospitals in every possible way. They have surely kept their pledge! To the chronically ill, the women of the Guild are eyes, ears, hands and feet. When the polio epidemic produced an emergency situation, the Guild responded whole-heartedly to the need for assistance. The members arranged to assist with the feeding of helpless patients so that professional staff might be relieved for

other duties. Many other patient comforts have been made possible as well. The Guild has provided the hospitals with paraplegic chairs, crutches, wheelchairs, physiotherapy and public address equipment, and furnishings for the new hydrotherapy unit. One other most commendable project has been the fund set aside for the benefit of patients who are studying in order to become self-supporting.

At Steinbach, Manitoba in 1938 eight women formed an Aid that now numbers almost 500 members. They are the hardest working group of women that one could meet. During the past five years they have given the hospital more than $12,000 in cash but triple that amount in linens, fruit, vegetables and other produce. The store-room looks like a supermarket.

The work done by the members of these volunteer organizations is vast. Without their help, our hospitals and their patients would be much poorer not only materially but spiritually.

Patient Care at Home

Home care programs have been discussed, planned and in some areas, tried. This is a report of a conference on Home Care; what it is, why we need it, how it could be instituted, and what implications it has for Canadians — patients, their families and the medical and allied services which they use.

THE Canadian Nurses' Association recently sponsored a conference in Ottawa on Home Care Plans. In a general introduction to this subject Miss Eli Magnussen gave some answers to current pressing problems. Invited to Ottawa by Miss Dorothy Percy, chief nursing consultant, Department of National Health and Welfare, Miss Magnussen, who is a nursing consultant with WHO and chief nurse of the Danish Ministry of Health, spent two and a half days at the VON Blackburn House as a resource person to the conference. Some of her comments follow:

Although there is an ever-increasing number of hospital beds, the demand continues to exceed the supply. Because of a broader philosophy which states that every person should benefit from advances in medicine, there has been a rationalization regarding those who require less technical or long-term care. Are nursing homes the answer?

The psychological effects of long institutionalization are mental disturbances and broken homes. When a patient is cared for at home a cooperative development takes place there. Having a patient to look after can often gather the family together.

Because there is a marked increase in the number of older people in our society there is also a proportionate increase in chronic and long-term illness. We live longer and we live longer with our diseases.

At the present time Denmark has a population of four and a half million.

	1959	1980
Over 60	624,000	945,000
In nursing homes	54,000	81,000
Confined to bed or wheelchairs	12,000	18,000

If these patients are to be cared for at home what are their needs?

Domestic — homemaker service such as, shopping, cooking, serving, etc. In Denmark, a homemaker is prescribed by the doctor for one to two weeks. For patients who are elderly or disabled another group called "home helps" meets long-term needs.

Social — entertainment and occupational activities through cooperative planning with professions other than medical and nursing e.g. occupational therapy, social service etc.

Medical and nursing — family doctor, nurse, and physiotherapist.

Who will evaluate the needs? Some patients will only need parts of the service. Who will administer the system? One method is a hospital-based system. This is an extension of hospital

services into the home. Nursing service can emanate from the hospital or the hospital can buy nursing service. A second method is a community-based system with administration being carried out by government health service.

The inauguration of a home care plan and its successful functioning have two important requisites — (a) inclusion of the philosophy of home care in basic education in medicine and nursing; and (b) cooperation with other professions. Without cooperation the plan will fail.

Following Miss Magnussen's introduction to the topic there was a symposium entitled "Roles and Relationships in Home Care Plans." Those who participated were:

Dr. Samuel Mirsky, DVA Hospital, Ottawa; Mrs. Doris Small, district director, Greater Montreal Branch, Victorian Order of Nurses; Miss Enid Wyness, director, Social Service Department, Ottawa Civic Hospital; Dr. William Storrar, medical director, Montreal General Hospital; and Mrs. Margaret Pincock, executive director, Visiting Homemakers' Association of Ottawa. Miss Helen McArthur, national director, Nursing Services, Canadian Red Cross Society was moderator.

The participants opened the discussion by defining home care plans. Although opinions differed as to the origin or administrative body of the service, all were agreed that home care was the provision of services such as are found in a hospital for patients at home. In order to establish a plan the hospital must be thought of as a community agency.

The doctor makes home visits and, with the cooperation of both the hospital nurse and the visiting nurse, makes recommendations for other services for the patient e.g. homemaker.

The visiting nurse is seen as the member of the team who could supply information about the patient's home, family, culture, religion and community relationships. In her efforts to rehabilitate him she recognizes ways in which he may help himself and assists him to do so. She is the one who is closest to the patient and his family and as such can act as a counsellor to help the family and the patient to live with his disabilities. In order to fulfil her role she needs to be included in the pre-transfer conference before he leaves hospital since she will continue to act as a coordinator of services.

The social worker must have a good working knowledge of the role and competence of others on the team. Specifically, she is a case worker. She and the patient "look at the problem together," after which she can tap the sources of help in the community. "The coordinator of the team," the social worker stated, "may vary from time to time as the patient's needs change."

The homemaker should take part in home care planning — for the program as a whole and the individual plan for a specific patient.

Several recommendations evolved from the discussion which followed the symposium. In Canada we require the initiation of more pilot projects to determine the type of program we need. This could be done at the provincial level with support from federal health grants. The hospital bed situation is going to force us to do something. With present health insurance coverage, government or voluntary, the patient at home has to pay for his own services, e.g., nursing care, drugs. Hospitals for the chronically ill are not the answer, for the reasons outlined by Miss Magnussen. Do we need better utilization of existing personnel and services, coupled with involvement of the family? Dr. Mirsky stated that

it is not an exacerbation in chronic illness that causes readmission to hospital but deterioration of the home situation.

The primary need at the present seemed to be greater coordination of existing resources. Later in the conference, there was extensive discussion of our present situation and the implications for future planning.

On the morning of the second day, three discussion groups were formed according to interest areas — hospital, public health and nursing education. The group to which a participant was assigned was not necessarily their actual field of practice.

Reports of Groups

Hospital: Education must be broad. Existing personnel must be helped to see the need for home care and to understand the meaning of it. There must be motivation of all hospital personnel.

Doctors are a very important part of the planning. Their education could be undertaken by a doctor who was both knowledgeable and enthusiastic. At the Montreal General Hospital where a VON liaison is on the hospital staff it has been found that the number of referrals are in direct proportion to the VON's liaison with the doctors.

This group stated that we are not utilizing our visiting nurse services to the best advantage. We need a good referral system and an increased awareness and appreciation of visiting nurse services by all hospital personnel. If home care, as it is now, was better understood it could be made available to all, rather than only the indigent. Some means of achieving our goals would be:

> A reorganization of hospital care along the lines of progressive patient care; exchange of doctors and nurses from hospital to community; enlistment of support of citizen groups; drawing student nurses into districts and chapters of our associations, and constant education and interpretation keeping in mind that "illness is only an incident in the life of the patient."

Public Health: This group reiterated the need for pilot studies with emphasis on making all facilities available, not on who coordinates. These studies would show that home care plans will streamline visiting nursing service — they will not overload hospitals but help them. We need a broader based type of care from the community as a whole — this requires re-education. The advantages of home care as outlined by this group are:

> More patients may be cared for; pressure will be decreased as the average stay in hospitals will decrease; decrease in waiting time to enter hospital; improved quality of care; the patient will want to vacate the bed; the patient will have greater peace of mind regarding his family; home care can help to lead society back into the home.

The nurse is the key person, who must think of the role of other professions and her own role as a citizen.

Nursing Education: The goals and needs require a three-way program of interpretation — to doctors, to the public and to nurses themselves. This group asked themselves a question and then attempted to answer it. What kind of a concept are we giving our student nurses?

Basic nursing education could provide first level preparation in all fields. This is not specialization but the application of the same principles to different situations. In order to do this most effectively schools need to be educational institutions — financially and administratively independent of hospitals. The group emphasized the need for a new approach in nursing because patients are in the community as well as in hospital. A recommendation came for continuing and expanding leadership from universities. A body of nurses is ready to support reappraisal of basic and post-basic education.

It was hoped that by evaluation and accreditation on a national level through CNA leadership we would head toward greater standardization of nursing education in Canada. Home care plans could spearhead the drive for comprehensive nursing.

These group reports were prepared prior to Miss Magnussen's final presentation "The Impact of Home Care Plans on Nursing Education in Denmark." She started by stating that education for and in home care can be divided into five areas:

1. Basic nursing education
2. Special education for public health nurses
3. Preparation of the present visiting nurse for her job in home care (The visiting nurse in Denmark has not received post-basic public health education at a university.)
4. Preparation of leaders in home care
5. Education of other professions and the public in home care.

Basic nursing education: Why do we insist on speaking of the need for integration of social and health aspects in the basic curriculum — why not just comprehensive care? In Denmark in 1957 schools of nursing were approved and accredited. This was done by the National Health Service and a board on which the national nurses' association had representation. A curriculum was set up for all schools by this central body and is now under dual control — the central board and the board of the individual hospitals.

A curriculum guide was sent to each school which outlines the minimum requirements. There must be a visiting nurse and a government health officer on each school board. It is recommended that a public health nurse (one with post-basic education in public health) be a member of the teaching staff. A tradition in Denmark is that a young girl spends one year in a home other than her own, helping the mother with her children and learning to take care of a home. This year is a prerequisite to entrance into a school of nursing and has been found to help the student nurse to adjust better to the hospital and broader nursing situation.

The *public health nurse* needs special preparation in the preventive aspects of nursing.

Education of the visiting nurse is done on an inservice basis. It is an ongoing process. At the present time the responsibility is in the hands of the government health officer in each district.

We need to *prepare leaders* in home care in our own profession so that existing services may improve as they grow.

Other professions: In some areas medical students have been given practical training in public health and hospital nursing. This can be very effective. We need to explore how physiotherapists, occupational therapists, social workers, etc., can work together for the furtherance of home care. Education of the public requires nurses "to get out and sell." No progress can be made until the public is ready. Nurses are slow in helping the public toward this readiness.

Miss Magnussen emphasized that the program of home care in Denmark is still young. It is also too soon to evaluate the effects of legislation on the schools of nursing.

We in Canada, will follow with interest the expansion of these projects planned to meet more adequately the health needs of the Danish people.

PAMELA E. POOLE

Mental Health Institute

The School of Nursing of Dalhousie University, Halifax will hold a three-day institute on "Nursing Aspects in the Mental Health Program," February 24, 25 and 26, 1960. The sessions will be held in the auditorium of the nurses' residence, Victoria General Hospital, Halifax. The registration fee will be two dollars ($2.00).

The conference leaders are MISS P. C. PIKE, head of the Psychiatric Nursing Research Department, Allan Memorial Institute, Montreal and DR. ROBERT O. JONES, professor of psychiatry, Dalhousie University. Nurses wishing to attend this institute should contact **Miss E. A. Electa MacLennan, director, School of Nursing, Dalhousie University, Halifax** as soon as possible.

* * *

We wish to remind subscribers to the *International Nursing Review* that, beginning with the February, 1960 issue, the Review will be published six times a year instead of quarterly. Owing to the rise in printing and mailing costs, as well as to the cost of more frequent publication, the subscription will in future be 30 shillings sterling per annum or $4.50.

— *ICN Newsletter*

* * *

A new professional film entitled "Cerebral Vascular Diseases: The Challenge of Management," has been released by the American Hearth Association. The film demonstrates the latest methods for aiding recovery and rehabilitation of stroke patients through use of services and equipment available to all physicians.

A version of this film for lay audiences, entitled "Second Chance," can be of help in instructing families of stroke victims on rehabilitation procedures and as a visual aid in addressing non-professional groups.

Both are 16 mm. black-and-white sound films, whose production was aided by a grant from E. R. Squibb & Sons, division of Olin Mathieson Chemical Corporation. Prints are available for purchase or loan from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

Interpersonal Relationships: a Classroom Subject?

Dorothy S. Starr, M.N.

Knowing how to get along well with others can lead to a more successful life for anyone. To be an effective nurse, this ability becomes a necessity. How can we help the nurse develop her understanding of people? Where do we start?

The way in which a student nurse gets along with other people — with her patients and with other members of the nursing team — is a primary factor in the quality of her nursing care. The student's relationships with others, in her professional capacity, are therefore the concern of all those responsible for guiding her learning experiences. Is there something to be contributed in the classroom to the student's ability to form positive, helpful relationships? Specifically, can psychology and sociology, taught after the preclinical period, contribute to her capacity for significant interpersonal relationships?

Psychodynamic nursing is a new term for part of the old concept of nursing the patient as a whole. It seems to involve the nurse — student or graduate — in a more conscious interaction of her own personality with that of the patient. Is the nurse, by being "sweet and kind," meeting the dependency needs of the patient or is she, in fact, retarding his tentative reach toward independence in order to satisfy her own needs? Is she too maternal toward her patient or not maternal enough? She needs to observe the effect of her personality upon that of the patient and to be conscious of what his personality does to her, in turn.

Some of the techniques for exploring the realm of interpersonal relationships which are described and upon which research is reported[1], seem to require greater maturity and a wider knowledge of psychology than that developed by most students in a three-year basic nursing program with a secondary school education prerequisite. It is to be hoped that nurses will continue to learn following their graduation and will use their increasing experience to perfect varying techniques of psychodynamic nursing — interviewing, for instance. This seems to imply inservice training for graduate nurse staff as the need for it is felt. The student nurse of today whose education places greater emphasis on awareness of interpersonal relationships may feel a desire to continue these studies in an inservice educational program.

The aim and goal of nursing is health. In all bedside nursing care the nurse is striving, in cooperation with the patient[2], to return him to health — not just physical health but with unimpaired psychic faculties and, we hope, with better resources to keep himself from illness in the future. There are some critics of nursing education today who say that nurses are forgetting their primary role and are moving into areas more properly served by doctors, social workers and psychiatrists. It is true that, consciously or unconsciously, in a skilled or an awkward manner, the nurse is dealing with the patient's emotional problems day-by-day. "She can bring psychotherapeutic or psycho-noxious attitudes and behavior to a particular situation."[3]

Two sociologists, reporting an analysis of the nurse's role, say that

> the nurse, as a member of the health team, is a professional and is obligated to hold the welfare of the patient as of primary importance. As the expressive specialist on this team, it is her function to lower the tension level of patients and to keep the doctor-nurse-patient relationship harmonious.[4]

Student nurses, like many people

Mrs. Starr is executive assistant to the associate director of nursing education, Ottawa Civic Hospital, Ottawa, Ont.

outside of hospital circles, are interested and intrigued by the psychiatrically-oriented material, accurate or distorted, which floods the mass communication media. In addition to her curiosity and to the introspection which belongs to adolescence, we urge upon the student nurse consideration of the emotional needs of the patient. We ask her to look behind the patient's words for his meaning.

There is a *continuum:* recognizing emotional content, communicating that content, by word or attitude, to the patient; interpreting that content to the patient. The latter function is that of the psychotherapist. The second is that of the nurse with greater skill than we can help the student nurse develop under present conditions. This would leave as our present task helping the student to recognize the possible meaning of what the patient does and says. This would further mean, it seems to me, that the student needs to be aided in understanding first what she means by her own behavior and verbalization.

Hildegard Peplau[5] expresses the nurse's personal factor:

> A nurse cannot pay attention to cues in the situation when her own needs are uppermost and require attention in the situation. Her observations are, unwittingly, focussed upon the way in which her unrecognized needs are being met by a patient. A good deal of advice has been given to nurses on how to behave in relation to patients; it is a rare book that points out, in addition, the fact that the nurse may generate anxiety and guilt when her own needs operate outside awareness and are not met by patients. However, until the actual needs of the nurse are met or identified, so that she is aware of what they are and how they function as barriers to the patient's goals, she does not have control such as is required for carrying out all of the "shoulds" and "musts" indicated in nursing literature. She cannot gain rapport with patients when her own anxiety restricts awareness and limits her attention and observation to what brings approval for her.

Obviously we cannot hope to help every student to self-recognition but we shall have accomplished much if we can help a student to do the following:

1. Accept her failure to come up to her ideal of a nurse in the belief that she can grow and change. As long as she cannot accept her failure and so hides it from herself, she cannot change.
2. Accept the patient as different from herself without making value judgments about his standards and conduct or, at least, recognize that differences in standards and customs exist.

The focus of a short course of discussion on psychology and sociology should be on recognition of some of the general principles of human behavior, with observation of these principles in practice on the wards, under the supervision of clinical instructors as an added ingredient to all bedside nursing care. It is only through experience and experimentation that these concepts will become part of bedside nursing. So long as they remain abstract academic principles they will not enter into the nursing care of the patient.

A group of psychiatrists[6] who studied this problem stated,

> The instructor of nursing personnel has, in her relationship with her students, a royal opportunity to help them in their relationship with patients. The instructor, too, has to evaluate her own uses of defences against anxiety. One of the most common defences is the zeal with which various "ologies" are taught. Knowledge and memory are emphasized. Nursing routines are laboriously checked. Close relationships, living relationships, are avoided.
>
> We probably can teach didactically very little of value to the nurse in terms of dealing with patients. We can, however, provide situations in which she herself can learn with a minimum of anxiety. The nurse may gradually reach a high point of tolerance of anxiety because of her own self-knowledge. With experience she can learn not only to appreciate the dilemmas of her patients but also to help them through their disparate efforts to cope with them.

The course, as I envision it, would be conducted as a seminar with relatively small groups of students, not more than 20 in each, who might be seated in a semicircle or around a table. The principles are presented by the instructor although her seat in the circle or around the table does not have the formality of the starched, behind-the-lectern stance. In a 12-

hour course, the first two lectures would be devoted to a review of principles of psychology involving: the concepts of homeostasis; the hierarchy of needs; the physiological manifestations of emotion; frustration and conflict; and mechanisms of adjustment. The third period is concerned with some of the feelings that hospitalization and illness may arouse in the patient.

The subject of the meaning of illness to the patient is presented to students in many ways and at various times. It seems wise to present the emotional aspects of illness in a way less closely related to the medical aspects of the patient's illness. The classroom makes a more objective appraisal of the patient-nurse relationship possible. The atmosphere is conducive to considering principles and applying them to specific patient situations while separated from the urgency and stress of the work situation. Illness as an event will have been discussed in the classroom during the student's preclinical term, but in her third year she will have her own experience from which to draw illustrations.

In the fourth hour some of the feelings which the nurse may have in relation to the patient and to the work situation could be discussed. No attempt need be made to elicit personal experience illustrations although frequently a student may offer one. The subject should be approached in a manner calculated to arouse a minimum of defence. Many nurses have feelings of anxiety, rebellion against authority, conflict over opposing goals, anger, ambivalence over dependency needs, frustration over the gulf between the ideal and actual performance.

The fifth and sixth hours can be devoted to considering the kinds of personal relationships developed between student nurses and patients. Students may be asked to record conversations between themselves and their patients for later group discussion along the following lines: What did this patient really want from the nurse? and, what can the nurse do for this patient, considering his feelings and her own?

Since social and psychological factors cannot be distinctly separated, sociology follows psychology in an unbroken series. In sociology an attempt is made to select those principles which have direct application to the student's nursing experience and to re-emphasize constantly the relevance of the subject matter to the care of the patient in the hospital or in the community. Six hours are used to present the patient as an individual in society, as a member of the family, and as a member of the community, with approximately equal amounts of time spent on each topic.

The two hours devoted to the patient as an individual in society (by inference, the nurse or anyone else as an individual in society) cover the concept of culture with its subdivisions of folkways, mores, institutions and laws, and the way in which an individual learns about the society in which he lives, including concepts of role and status within the group.

The subject of the family is of great importance to the nurse. This topic provides perhaps the hardest task in selecting material to be included in a very short course. Mention is made of some of the forms of family structure, of the function of the family, and of the cultural changes in life on the North American continent and their effect upon family life. In the second hour, the family cycle is considered. The student is asked to discuss how a family changes when the first baby arrives, the pressure on family life when the children begin to leave home, and the readjustment in family life that aging brings.

Consideration of the patient's life in the community includes some discussion of housing; the ecology of cities; segregation, voluntary and involuntary; and the effect of housing on health problems. The last class period is centered on the groups in which the patient, or anyone else, lives and includes discussion of race, social class, ethnic and nationality groups. Again discussion is based on fact, as opposed to popularly-held misconceptions, and the effect that these divisions of mankind have upon health problems.

Another 12-hour course in ward administration primarily considers the relationship of the nurse to hospital personnel. In this course role-playing is used to help the student nurse

experience some of the situations in the protected environment of a small group in the classroom. Students role-play such situations as: the head nurse who must reprimand a student for failing to keep an intake-and-output record; the clinical instructor who investigates a student's indifference to the geriatric patient; the patient who complains to the student of her doctor's short visits and apparent lack of interest.

Discussions following role-portrayal center around: How would you have handled this situation? How would you have felt if you were in this position? Why don't you like to tell another member of the nursing team of an omission when it is your responsibility as team leader to see that all patients are given good nursing care?

The classroom teaching of interpersonal relationships in terms of psychology and sociology is aimed at introducing the student to new ideas and to a few basic concepts of these social sciences, in an atmosphere where she can learn and experiment with a minimum of anxiety. We feel that the classroom has a contribution to make to the student's capacity for significant interpersonal relationships.

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Nurse-Patient Relationships

CATHARINE BLACKLOCK

Success or failure! Good relationships can decide the effectiveness of your nursing care. Technical skill alone is only half the answer.

TECHNICALLY speaking, a relationship implies a state of being mutually or reciprocally interested. It is now apparent that nurse-patient relationships are as important as clinical skills in the basic principles of nursing care. There is a need for a well-defined philosophy of life as a basis for establishing more positive attitudes. The personality of the individual nurse is a very important factor in effective nurse-patient relationships.[1]

The nurse is now being educated to treat the patient not just as an appendectomy or a tonsillectomy, but as a living, feeling human being temporarily or permanently incapacitated by illness. To give this type of care, she must be prepared to help the patient psychologically and socially.

Miss Blacklock recently returned to Canada after several years as surgical supervisor at Mount Sinai Hospital, New York.

Psychological Preparation

"The same fire that melts the butter hardens the egg." Every personality develops continually from infancy until death, and throughout this span it persists even though it changes. Psychology is the study of behavior or misbehavior. It is the science that seeks to understand the activities of the individual. The individual is a

vital personality reacting to the environment created by his illness. Recognizing this interrelationship, it is obvious that the skillful nurse must minister to the patient's emotional needs as well as to the physical aspects of his pathological condition.[2]

The nurse has a more urgent need for psychology than most professional people. She needs to understand the basic principles of behavior not as abstract concepts, but as workable, practical aids which will assist her in recognizing how best to serve her patients and how to deal most tactfully with troublesome situations. She, more than anyone else, can stimulate the desire to live and to get well. She must have an interest in and a liking for the patient in order to enable him to return this feeling. She must have patience and understanding and be willing to listen. Each individual differs from all others and must be treated accordingly.

Sociological Preparation

The nurse should know and recognize her potential contribution in the various fields of social welfare. She should be prepared to:

give better nursing service to the patient; interpret the patient's problems to his relatives and friends; cooperate effectively with the physician in understanding the patient; learn more about the interrelation of health, social conditions and problems; contribute in greater degree to nationwide programs for health; carry out more intelligently federal or provincial welfare legislation such as the Workmen's Compensation laws.

The patient in thinking of his recovery, whether partial or complete, often must adjust to other and perhaps greater problems than his present condition. The nurse's first-hand study of social problems begins with the individual. She influences the total problem by the way in which she helps the patient. The patient's personality is an important factor in social adjustment.[3]

To treat this subject fully, it is necessary to consider the nurse-patient relationship in all types of hospitals and in the home.

In the General Hospital

In dealing with the patient in a general hospital, view him as having healthy potentialities and treat him accordingly. Ill patients have normal sensitivities. If anything, these sensitivities are more acute than normal. The nurse's function is to create situations that provide an opportunity for wholesome, balanced activity at the patient's level.[4]

In all nurse-patient relationships the nurse exerts inevitable influence. This influence is for good when she is a mature, generous, humble, understanding individual with a stable, wholesome personality structure that rises above irritations, resentment, pettiness and a narrow point of view. Successful relationships depend less on efficient administration of drugs and manipulation of equipment than on spirit, attitudes, values and sensitivities put into useful social practice. The nurse is not merely a dispenser of care. She is a vital part of it — a prime mover in all efficacious patient-nurse relationships.

Quite often the patient responds to stimuli so quickly and so vehemently that one can see the effect of care and especially the consequences of general attitudes and behavior. He teaches the nurse the importance of reciprocity in human relationships, and the need for honesty in social relationships.

Through contact with the patient one gains the experience that perfects study. Knowledge acquired in the classroom simply places the nurse in an intellectual relationship with the subject matter. It is while dealing with the patient that she has flashes of insight into his point of view. At the highest level, patient and nurse think and plan together, each aware of the particular contribution made by the other.

There are four levels of participation: coercive, permissive, directive, cooperative.[5]

1. The lowest level of participation is *coercive*. This is often necessary when force is needed as in the enforcement of communicable disease control or in the hospitalization of the psychotic patient. This is naturally not a satisfactory relationship for the patient or family.

2. A *permissive* relationship takes place when the patient is persuaded to accept treatment or to follow advice.

though he really does not want to do so. In this type of relationship the nurse decides and the family accepts but does not participate in the decision.

3. More satisfactory is the relationship in which the patient and nurse share in discussion and in planning. This may be called a participating relationship. It is really only *directive* but it allows the family to exercise some selection and choice in decisions.

4. When the patient or family and nurse are able to work jointly in the analysis and solution of problems and each contributes to the fullest extent throughout the entire process, the relationship may be described as *co-operative.*

Resistance to the efforts of the nurse may mean that while the patient needs help he is loath to get involved with ideas and plans that mean change. Change is a threat to established daily living which may not be comfortable itself, but is more comfortable than change. Change brings the necessity for thought and decision with subsequent feelings of discomfort unless happy results are quickly obvious.

A Formula

1. Actual interest in the patient's point of view and genuine respect for it — not assumed respect as a device for sugar-coating her "message."

2. Appropriate health information based on available research.

3. Skill in bedside nursing.

4. Belief on the part of the nurse that her professional purposes are of value.

This is a working formula which includes the emotional aspects and is designed to make the patient feel that identification with the nurse is worth while. It is not easy to go slowly, to stop for thought, to be aware of one's own reactions, to be willing to relate oneself to the lives of others rather than to direct them. The sum total is the straight road to a working relationship with the patient.

In the Special Hospital

In a large class of diseases mental symptoms take predominance over physical and are the first consideration in treatment and care. Before coming to the psychiatric ward, most nurses have the idea that all people who are mentally ill are irrational and do not understand what goes on around them. One of the fundamental ideas to grasp early is that the patient, regardless of his behavior, is a human being who thinks, loves and hates and has quiet and acute sensibilities. Pleasant reactions are very near the surface. They require only the right stimulus. Even with the unwholesome, disagreeable and sometimes offensive symptoms of mental illness, probably there are more sensitive, noble souls to be found in hospitals for the mentally ill than in any other one place. At heart the psychiatric patient is friendly and good. Unpleasant, perverse, unreasonable behavior is all part of his illness and corresponds to the fever, vomitus and vile breath of the patient on the medical and surgical ward.

Personality factors are stressed in nurse-patient relationships here because every word and act produces a positive or negative influence on the patient's immediate condition. Nurses, like other people, may be one of two fundamental personality types: those who focus primarily on people and those who focus primarily on things.

In dealing with the patient the nurse does not use little bits of energy now and then. It is necessary to think continually. Within her own mind, she establishes immediate and ultimate nursing objectives. She considers suggestions and associations that give meaning to the patient's behavior of the moment and plans a way to get the patient's state of feeling in line with the need. Getting the mood or the attitude of the patient in line with the need is something one learns by oneself for oneself.

Achievement in psychiatric nursing depends on the management of interpersonal relationships. This includes applying knowledge, spirit, interest, objectivity, tenderness in intellectual action. Through the behavior of the nursing personnel it is possible to make a patient feel calm, comfortable, secure and thereby change noise and uncontrolled activity to quiet and order. The nurse can see now more clearly and more specifically how better knowledge of human behavior fortifies her daily work, and how nursing can become part of the current mental hygiene program.

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In the Home

When the public health nurse offers her services to people who could profit from her knowledge but are not acutely ill or in obvious danger of illness, she finds herself entering upon a more complex situation than is presented in nursing the sick patient. Successful health teaching depends upon the relationship between the nurse and the individual. The latter must be made to feel that the nurse has some valuable information to offer him.

The use of the word "relationships" in a professional sense, while enlarging its meaning may obscure the original and still useful sense of the word for laymen or members of another profession. When you consider the relationships between two persons, as for example between the nurse and the person in the community with whom she forms a contact, one asks first whether the two "get on" together. Then you must consider how or on what basis they maintain their relationships. There is a need to study the attitudes of both, the interplay between them as revealed by their behavior, and finally the usefulness or fertility of the relationship in view of the objective in mind — here the teaching of health.[6]

When the patient accepts:

Many of the patients who welcome the help of the nurse are mature and well-adjusted. They are glad that a source of information on health matters is available. They recognize their own problems, and are even able to see their own mistakes. They may seek to make use of the nurse in many ways. These range from legitimate use of her superior health knowledge by people in need of advice in such matters, through an emotional dependency which may help or hinder according to the individual situation, to an attempt, often unconscious, on the part of the patient with marked personality problems to fit into the defense they have worked out for making life more endurable.

When the patient resists:

The nurse's ideals for her own conduct influence her methods of work with the patient. Unconscious emotional reactions on the part of the nurse may be a source of danger to the patient. The nurse should not try to judge the family by her own standards. Often she has a lack of understanding. The patient may be emotionally immature, or perhaps looks upon the nurse as a superior person unable to help her in her difficulties. If the emotional and intellectual needs and status of the patient are taken into consideration so that the information the nurse can offer is specific and appropriate, many of the other difficulties in making a "good" visit will be eliminated almost automatically.

Once a contact in the home has been established, the nurse must consider who is the "key person" in the family. Clarification of a difficult situation may follow a thoughtful selection of the member of the family with whom the nurse shall attempt to work out the strongest relationship. Sometimes it is a high school girl who frequently becomes more interested in family nutritional needs than a foreign-born mother. She can be depended upon to make use of her new ideas in the family since they are proud to accept this evidence of the child's progress. One pitfall that frequently endangers the nurse's relationships with the family is identification of herself with one member of the family who appears to warrant special sympathy and protection or with a certain faction in the family.

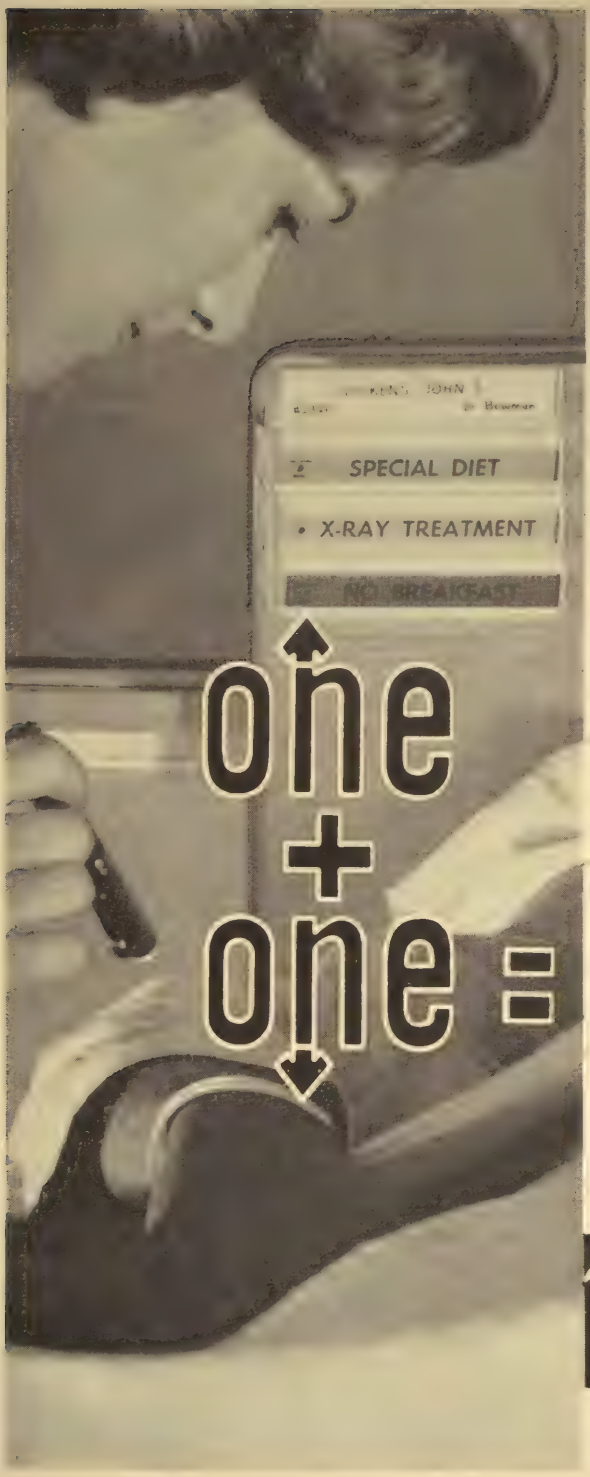
Obtaining insight

1. *Listening*: The opportunity to tell his fears and anxieties to a tolerant person who is not part of the situation yet understands what he is talking about, leaves the patient feeling that he has actually lost some of his troubles in the act of talking about them. This willingness on the part of the nurse to listen to him is a help to the patient and also aids the nurse.

2. *Questioning*: This is an activity which cannot be separated from learning. Unless the patient is under pressure to talk to the nurse because of his own interest or excitement, it may be the nurse's skilled questioning which will helpfully tap the reserves of the patient's feelings and will permit the nurse and the patient to understand each other more fully.

The nurse and the group

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health conference. She must ensure that speed, efficiency and the pressure of habitual routine do not blind her to ineffective results which may affect the children and the mothers who are attending the conference.

Any nurse who has conducted child health conferences has seen the therapeutic effect that this experience may hold for the child who is afraid or shy. Through observing him as one of this group she may learn to understand that the child's behavior is natural rather than "bad."

In conclusion it can be stated that: A good relationship is one that allows the nurse to accomplish in the most effective manner possible the task for which she has come to help the family or the individual.

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In the Good Old Days

(*The Canadian Nurse*, FEBRUARY, 1920)

The Necessity for Breast Feeding

A French medical journal, describing the work of the well-baby clinic at Lille during the German occupation, says that there was one unforeseen result. As the Germans carried off all the cows there was no milk; as the factories were not running, the women could not find wage-earning work, and were obliged to stay at home with their babies. The mothers were forced to nurse their infants to keep them alive and the infantile death rate was far lower than was ever known before in the town. He concludes that milk-distributing stations are a mistake, as they relieve mothers of their first duty.

* * *

The Industrial Nurse

It is stated that the first trained nurse to be employed as an industrial nurse was one engaged by the Vermont Marble Company, in 1895, to visit the homes of the employees and care for the sick mothers and babies.

* * *

Training School Requirements

The girl who enters a training school has a right to be given full and proper instruction. Likewise the public has a right to demand that, when a nurse assumes the responsibility of caring for the sick, she shall be fully qualified.

No hospital should be allowed to establish a training school unless it comes up to a required standard set by a governing body who are qualified to judge and determine what that standard shall be.

* * *

Registration in Britain

Congratulations from this magazine and from all the nurses of Canada to our sisters in England for the successful ending of their strenuous appeal to Parliament for registration, which has lasted for fourteen years . . . The law will enable nurses to organize their profession so that it may be a more efficient instrument for the service of the sick and suffering, and to raise the standard, through preventive work, of the national health.

Much outcry, little outcome. — AESOP

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Drug Addiction

JOHN GIBSON, M.B., Ch.B., D.P.M.

The drug addict — pitied or scorned? Addiction — sickness or crime, curable or incurable?

A DRUG addict is a person who takes excessive amounts of a drug or for prolonged periods without medical indications, develops a tolerance, and shows symptoms of withdrawal if he cannot get or is not given the drug. Most addicts show psychopathic traits before they become addicts. It is rare for mentally normal persons to become addicts, with the possible exception of some who are addicted to barbiturates. Any drug with sedative or hypnotic properties can become a drug of addiction. It is also commonplace knowledge that any drug used to relieve the symptoms produced by the withdrawal of another drug is itself likely to produce addiction. In some parts of the world, drugs are taken daily in small amounts by large numbers of people and produce mild addiction, for example opium in the Far East, cocaine in South America, and hashish (marihuana) in Africa and Asia. Of the drugs prescribed medically, the ones that commonly produce addiction are the barbiturates, opium and morphine, heroin, pethidine, cocaine, paraldehyde and amphetamine.

Barbiturates

Because of the large amounts prescribed for many nervous symptoms, addiction to barbiturates is probably now the commonest of all addictions in the western world. Patients thus treated can easily develop a dependence upon the drug and will show symptoms if it is withdrawn. That the patient has developed a tolerance for the drug can be deduced when he is able to take it by day and not become sleepy. Chronic intoxication with the drug may produce a state of hypomania resembling drunkenness, with an irritability and moodiness that the addict tries to relieve by taking more of it. Barbiturates are presently a common cause of accidental death and suicide. Withdrawal of the drug produces irritability, anxiety, tremor, sweating, palpitation and insomnia. The occurrence of any of these may, unfortunately, be taken as evidence of the continued existence of the mental state for which the barbiturate was originally prescribed. Treatment is by withdrawal of the drug and simple psychotherapy.

Opium and Morphine

In the Far East addiction is common since opium is commonly taken by mouth or by smoking. In other parts of the world the incidence of this particular addiction is highly variable. Its variability depends upon the number of psychopaths in the community and the strictness of the precautions taken by the state to control manufacture, prescription and sale. Addiction usually begins in early adult life and is often associated with addiction to other drugs.

Some addicts are happy on relatively small doses of drug, which they do not have to increase and on which they may be able to live happily and work efficiently as long as they are able to obtain it. Others take increasingly larger amounts with severe physical and mental effects. The addict develops a loss of appetite, constipation, malnutrition, anemia, abscesses at the sites of injections, and a poor resistance to infection. Mental changes include further development of psychopathic behavior, in particular unreliability, lying and stealing in order to obtain the drug. If the drug is withdrawn, withdrawal symptoms begin in about 24 hours and are at their worst in 72 hours, after which they abate. They include headache, nausea, vomiting, diarrhea, anxiety, restlessness and insomnia. The symptoms are so distressing that few addicts are willing to endure them.

Treatment is by rapid withdrawal of

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the sixth of a series of articles on psychiatric subjects.



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the drug over the course of three or four days. More gradual reduction is useless. Sedation is accomplished by the use of barbiturates, paraldehyde or methadone. The latter is itself likely to produce an addiction, although a milder one. Modified insulin treatment and subsequent psychotherapy are also used. So unreliable are the patients that treatment can be carried out only in a hospital or in the home where full supervision can ensure that the addict has no access to the drug. Many addicts abandon treatment and relapse is all too common.

Heroin

Diamorphine hydrochloride produces addiction easily. It may be preferred by some addicts because of the intensity of the euphoria and the freedom from vomiting and diarrhea. Severe physical and mental deterioration is produced, and the addiction is very difficult to cure.

Pethidine

This is a synthetic drug that is used as a substitute for morphine in the relief of pain, spasm and cough. Addiction to it is more severe than that produced by morphine. It is more rapidly acquired and very difficult to cure. Tolerance and dependence develop quickly but some addicts have killed themselves with overdoses. With large doses tremors, twitchings, convulsions, confusion and hallucinations may occur. Addicts often take other drugs as well. Treatment is as for morphine addiction and is usually as unsuccessful.

Cocaine

This drug is taken by subcutaneous injection or as snuff which may cause perforation of the nasal septum. Addicts are usually grossly psychopathic, often existing as female or male prostitutes, alcoholics, or multiple-drug takers. Cocaine produces elation, overactivity, freedom from fatigue, facile thoughts, glibness and restlessness. When the effects begin to wear off, apathy and depression drive the addict to take more. Short-term psychoses may be produced in which the addict is confused, deluded, hallucinated and paranoidal. Treatment by withdrawal or any other method is rarely successful because few cocaine addicts are willing to leave the sort of society in which the cocaine habit is practised.

Marihuana

Hashish or Indian hemp produces a euphoria that once experienced is usually much desired. It tends to produce excitement, irresponsible behavior, a delirious state and violence. "Reefer" cigarettes containing it are said to be smoked by dance-band players to produce an extra frenzy in their playing.

Paraldehyde

This preparation is occasionally taken in excessive amounts by alcoholics in spite of its persistent and unpleasant smell. It is important that alcoholics should not be prescribed paraldehyde, except during the acute phase of delirium tremens when it is the safest hypnotic to give.

Amphetamine and Dexamphetamine

These preparations are taken to overcome fatigue and depression, to promote efficiency and alertness, and to acquire confidence. They may become drugs of addiction. Some people develop a great tolerance for them. They may produce irritability, restlessness, overactivity, insomnia, exhaustion, aplastic anemia, and short psychotic reactions with delusions and hallucinations as prominent symptoms. Withdrawal produces anxiety, restlessness and insomnia.

Time sterile indicator is a dramatic chemical applied to a pressure sensitive paper tape which is used as a label. The tape can be applied to every type of glassware or instrument. The colorless TSI will turn from nothing to an indelible black word "Sterile" only after a specific standard sterilizing cycle of 15 minutes or more in a sterilizing oven or autoclave. For further information write to: Professional Tape Co., Inc., 355 Burlington Road, Riverside, Illinois.

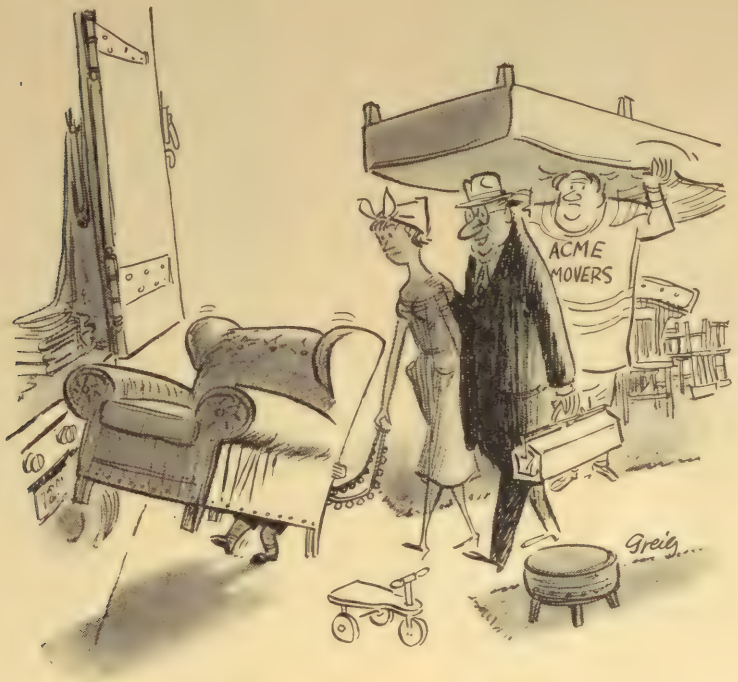
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THE GOOD THEY DO NOW—LASTS A LIFETIME

A Step Forward at Thistletown

Sue Moore

The emotionally disturbed child! A sorry thought, to be sure, but this author is no longer sad; she paid a visit to Thistletown.

Just inside the boundary of Metropolitan Toronto a winding road leads to the entrance of a large, pleasant building surrounded by 98 acres of partly wooded, slightly hilly countryside. There, in the summer months normal-looking children can be seen playing. Behind these normal appearances, however, there are many strange and serious anxieties, for these are emotionally disturbed children.

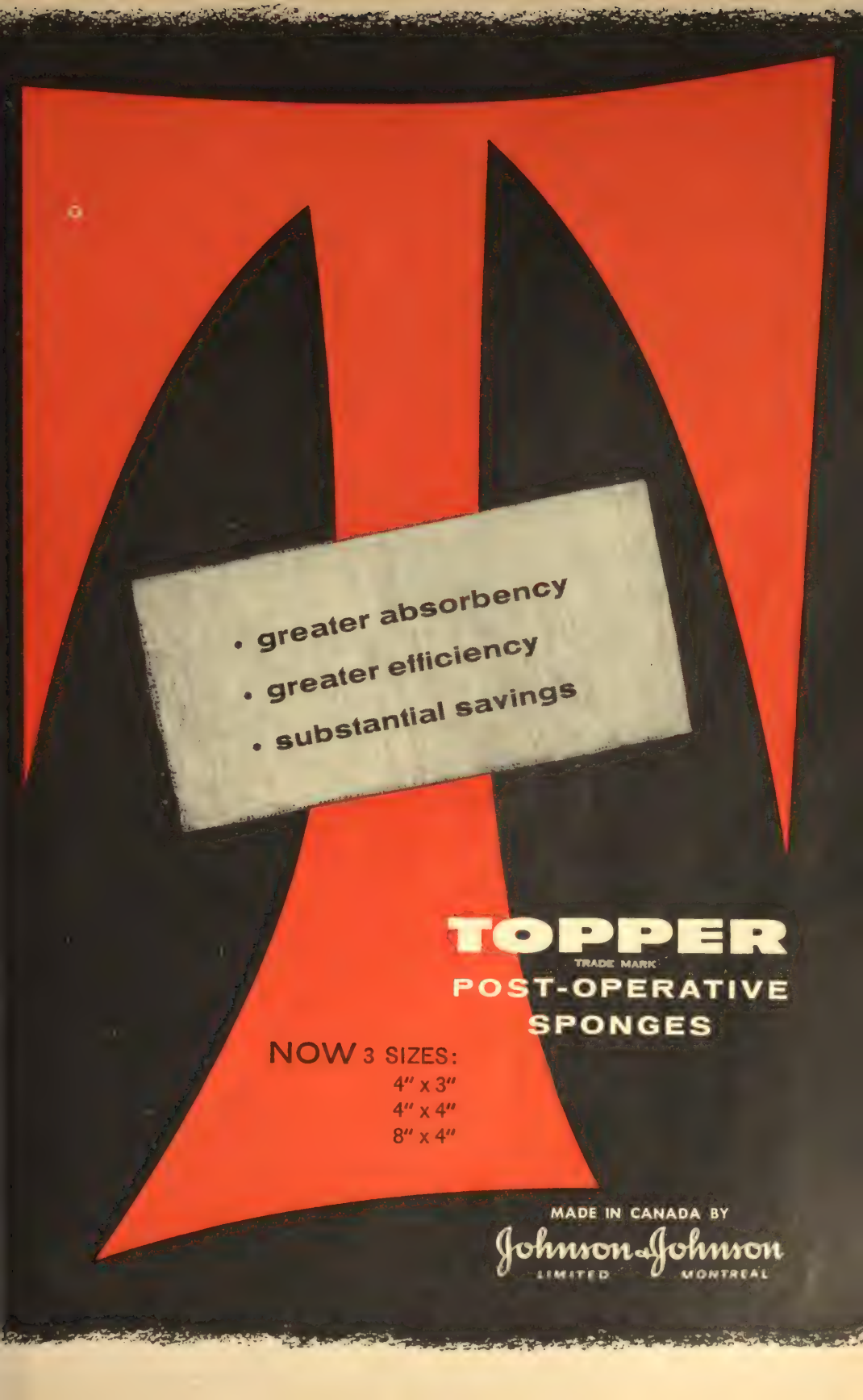
The building is Thistletown Hospital, constructed in 1929 as the country branch of the Hospital for Sick Children, Toronto. On February 8, 1957 the Ontario government announced the purchase of Thistletown, to be used as Canada's first psychiatric treatment centre for children. This purchase was the result of a survey made by Dr. W. R. Keeler, which revealed the serious lack of residence facilities in Canada for the treatment of emotionally disturbed children. Throughout Ontario there are several outpatient services and small residential centres such as, the Sunnyside Children's Centre in Kingston and the Protestant Children's Village in Ottawa, but these are essentially for less severely disturbed children. Facilities were needed which would provide the more extreme cases with constant observation and treatment in a protected and understanding environment. Thistletown was the answer though at the time of purchase it was still only an idea and a hope.

In January, 1959 I saw it as a reality, and was considerably impressed by the progress that had been made since it was opened the year before. The interior of the building had been redecorated. A gymnasium and a swimming pool were being added.

The building is now made up of three wings. The first contains offices for doctors, social workers, an occupational therapist and the dentist. The other two wings divide naturally into four living areas. On the lower floor are two wards for boys and girls under twelve years. These contain several large rooms, with varying numbers of beds. At the end of each ward there is a spacious, cheerful playroom where the children spend a great deal of time with their counsellors. There are two similar wards on the upper floor that are not in use yet but will eventually house adolescents. When the hospital is in full operation it will accommodate 72 children; during my visit there were only 18. In the basement there are more rooms for recreation including two small gyms, a workshop and a ceramics room. Here, qualified staff members teach the children to use their hands and to express themselves through building and modelling. At the end of the hall there is a rather formidable looking room with barred windows and mats on the floor. This room is used when a child gets out control. Instead of leaving him to overcome his anxiety alone a doctor or counsellor either goes into the room with him or waits outside until he has calmed down enough to talk. In this way treatment is administered as soon after the disturbance as possible instead of waiting for four or five hours when the child will not really care about it.

I was also shown the cafeteria where a counsellor was eating at each table with two or three children. Next to it was an interesting playroom. Along one side was a wide strip of mirror; opposite was a similar sheet of glass resembling a window. The children could not see through it but in the little room next door the doctors could watch and hear their patients at play. This enabled them to discover factors about the children

Miss Moore was a student in Queen's University School of Nursing, Kingston, when this visit was made.


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which might not be evident if the doctor was present.

Thistletown is administered by the Mental Health Division of the Ontario Department of Health. The aim of the hospital is to provide a centre for the residential treatment of emotionally disturbed children from six to seventeen years of age. There is often misunderstanding of the expression "emotionally disturbed"; many people interpret it as meaning retarded. This is not correct. Most of the children at Thistletown have relatively high IQ's, although some may be retarded as a result of their emotional disturbance.

Admission to the hospital depends upon the severity of the child's disturbance, and the presence of some indication that he will benefit from the hospital's program. After being recommended by a psychiatrist the child is interviewed at an outpatient clinic, and accepted only after careful consideration by the doctors at Thistletown. There is a very long waiting list.

There is a great variety of emotional illness treated at Thistletown. Some of these disturbances are: neuroses, primary behavior disorders, certain types of delinquency, brain damage and epilepsy combined with emotional disorders, and psychotic illnesses of all types including autism or childhood schizophrenia. Many of these behavior problems have been accentuated by a lack of love or an unhappy home life. The disturbances cause various reactions; some of the children are agressive and even violent whereas others withdraw from society and may not move or speak for several hours.

Several types of treatment are used to try to gain understanding of these anxieties, and to prepare the children to return to their homes. In individual psychotherapy the doctor talks with the child, in the hope that he will reveal something of his difficulty. This approach is more effective at Thistletown than at an outpatient centre because the child is able to discuss any emotional upset at the time or soon after it has happened and is more likely to be aware of his trouble.

Particular emphasis is being placed on *milieu therapy*. In this the treatment depends upon all the child's surroundings and the people who come in contact with him. Everyone on the staff is trained to understand and take an interest in each child so that he is constantly undergoing therapy. One part of this procedure which is especially beneficial is the practice of having ward meetings; they take place at the end of each eight-hour shift, and anyone on the staff who is free may attend. The children are discussed individually, and any recent incidents with, or unusual observations of a child are brought up. Since these children react very differently to different situations these sessions result in a better understanding of the child, by everyone.

Another type of treatment used is *play therapy*. The occupational therapist is especially interested in it. In the large sunny playroom she can do wonders with the children by means of various games. She told about one little boy named Jimmy who, at times, would be extremely aggressive and at other times would withdraw completely into a world of his own. Her job was to help him face reality so that he would eventually arrive at the level where he could talk to the doctors and associate with others. She began by spending a certain length of time each day with him. At first he threw blocks at her, so she put these away and began making paper puppets, such as a witch to represent a naughty child and an angel, a good one. After a while Jimmy began making the puppets himself, unconsciously expressing his world of fantasy. By this means and later by more complex games, he took steps toward a return to reality.

Another thing which I found very interesting was the treatment and interpretation of *misbehavior*. During my visit it was discovered that five boys had broken a window and had run away. I was surprised that no one seemed especially alarmed, but was told that this was quite a common occurrence. The grounds are large and the town small so that the children never get very far. When the children returned they talked to the doctor and each was given the punishment that would do him the most good. This action, which seemed punishable to me, was actually a step in the direction of recovery. The children had cooperated in a group, whereas previously

WHY KNOX SPECIAL DIET BROCHURES ARE BASED ON FOOD EXCHANGE LISTS





VEGETABLE LIST

Each of the following food choices contains little carbohydrate, protein or calories.

1200 CALORIE DIET · Choice of any number

1600 CALORIE DIET · Choice of any number

1800 CALORIE DIET · Choice of any number

In Raw Form, Size of Serving Unlimited; Cooked, Size Serving ½ to 1 cup.

Asparagus	Eggplant	Dandelion
Broccoli	Lettuce	Kale
Brussels sprouts	Mushrooms	Mustard
	Okra	Spinach
Cabbage	Pepper	Turnip greens
Cauliflower	Radishes	Sauerkraut
Celery	Greens:	String beans
Chicory	Beet greens	Summer squash
Cucumber	Chard	Tomatoes
Escarole	Collards	Watercress

OR You may choose from this vegetable list. Each of the following foods contains 7 grams carbohydrate, 2 grams protein, 35 calories.

1200 CALORIE DIET · Choice of any 2

1600 CALORIE DIET · Choice of any 4

1800 CALORIE DIET · Choice of any 4

One Serving Equals ½ cup.

Beets	Peas, green	Squash, winter
Carrots	Pumpkin	Turnips
Onions	Rutabagas	

BREAD LIST

Each of the following food choices contains 15 grams carbohydrate, 2 grams protein, 70 calories.

1200 CALORIE DIET · Choice of any 2

1600 CALORIE DIET · Choice of any 4

1800 CALORIE DIET · Choice of any 3

	Amount to Use
Bread	1 slice
Biscuit, roll (2" diameter)	1
Muffin (2" diameter)	1
Cornbread (1½" cube)	1
Cereals, cooked	½ cup
Dry, flake and puff types	¾ cup
Rice, grits, cooked	½ cup
Spaghetti, noodles, cooked	½ cup
Macaroni, cooked	½ cup
Crackers, graham (2½" sq.)	2
Oysterettes (½ cup)	20
Saltines (2" sq.)	5
Soda (2½" sq.)	3
Round, thin	6
Flour	2½ tablespoons
Vegetables	
Beans and peas, dried, cooked (lima, navy, split peas, cowpea, etc.)	½ cup
Baked beans, no pork	¼ cup
Corn	⅓ cup
Popcorn	1 cup
Parsnips	⅔ cup
Potatoes, white	1 small
Potatoes, white, mashed	½ cup
Potatoes, sweet or yams	¼ cup
Sponge cake, plain (1½" cube)	1
Ice cream (omit two fat choices)	½ cup

MILK LIST

Each of the following food choices conta
grams carbohydrate, 8 grams protein, 10 gr
and 170 calories.

1200 CALORIE DIET · Choice of

1600 CALORIE DIET · Choice of an

1800 CALORIE DIET · Choice of

	Amoun
Whole milk (plain or homogenized)	
*Skim milk	
Evaporated milk	
Powdered whole milk	
*Non-fat dry milk solids	
Buttermilk (made from whole milk)	
*Buttermilk (made from skim milk)	

You can use the milk on your meal plan
in coffee, on cereal, or with other foods.

*Skim milk products contain less fat. When used
whole milk add 2 fat choices to get the same food v

FAT LIST

Each of the following food choices contains
fat, 45 calories.

1200 CALORIE DIET · Choice

1600 CALORIE DIET · Choice of

1800 CALORIE DIET · Choice of

	Amou
Butter or margarine (1 small pat)	1 tea
Bacon, crisp	1 sli
Cream, light	2 tal
Cream, heavy	1 tal

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e	1 tablespoon
diameter)	½
ing	1 tablespoon
	1 teaspoon
g fat	1 teaspoon
	6 small
	5 small

ST

following food choices contains 10 ydrate and 40 calories.

LORIE DIET · Choice of any 5

LORIE DIET · Choice of any 5

LORIE DIET · Choice of any 5

	Amount to Use
ameter)	1 small
	½ cup
sh	2 medium
ed	4 halves
	½ small
	1 cup
	1 cup
	1 cup
	⅔ cup
6" diameter)	¼
	10 large
	2
	2 large
	1 small
	½ small
ice	½ cup
	12
	¼ cup
elon, medium	⅛
	½ small
	1 small
	½ cup

Papaya	⅓ medium
Peach	1 medium
Pear	1 small
Pineapple	½ cup
Pineapple juice	½ cup
Plums	2 medium
Prunes, dried	2 medium
Raisins	2 tablespoons
Tangerine	1 large
Watermelon	1 cup

You may use your fruit fresh, dried, cooked, canned or frozen as long as no sugar has been added.

MEAT LIST

Each of the following food choices contains 7 grams protein, 5 grams fat, 75 calories.

1200 CALORIE DIET · Choice of any 4

1600 CALORIE DIET · Choice of any 6

1800 CALORIE DIET · Choice of any 6

	Amount to Use
Meat and Poultry *(medium fat)* 3-4 Oz. Average Serving (Beef, lamb, pork, liver, chicken, etc.)	1 ounce*
Cold cuts (4½" x ⅛") Salami, Minced Ham, Bologna, Liverwurst, Luncheon Loaf	1 slice
Frankfurter (8-9 per lb.)	1
Egg	1
Fish: haddock, flounder, bass, 3-4 Oz. Average Serving	1 ounce*
Serving Salmon, tuna, crab, lobster	¼ cup
Shrimp, clams, oysters, etc.	5 small
Sardines	3 medium
Cheese, Cheddar type	1 ounce
Cottage	¼ cup
Peanut butter	2 tablespoons

**Equals 1 Meat Choice; 3 oz. serving uses 3 Meat List Choices.*

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As a hot drink *(with Bouillon).* Sprinkle 1 envelope Knox Gelatine on ¼ cup cold water to soften. Add 1 bouillon cube and ¾ cup boiling water. Stir until gelatine and bouillon cube are thoroughly dissolved. ¾ cup of any very hot broth may be used in place of bouillon.

After you have reached your weight goal . . . take Knox "Booster" Drink (with milk) to maintain weight and to supply additional protein. 1 (8 oz.) glass contains 15 grams protein, 130 calories. In an 8 or 10 oz. dry glass, thoroughly mix 1 envelope Knox Gelatine with 3 to 6 tablespoons *instant* non-fat dry milk (varies with brand). Fill with cold water. Stir briskly until milk thoroughly dissolves. Drink quickly.

OD EXCHANGES

1. are authoritative[1]
. eliminate calorie counting
ovide a wide variety of food
. assure a balanced intake
otein,* carbohydrate, and fat

1. The Food Exchanges Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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each had kept to himself. Almost everything that happens at the hospital is converted into a contribution towards the children's recovery.

School is held at Thistletown in a classroom similar to a regular one. There is only one teacher at the hospital now, but eventually they hope to have a principal and five teachers.

The rest of the staff consists of several psychiatrists, a psychologist, group and case social workers, a part-time dentist, an occupational therapist and approximately one counsellor or child care worker for each child. These counsellors work on eight-hour shifts since no one on the staff lives right in the hospital. It is felt that a change of environment is a necessity for the staff.

The training program for the counsellors or child care workers is one of the main projects of Thistletown and is an important part of the new plan. They come from varied background and experiences; some have only high school graduation whereas others have university degrees or training in a special field. A one or two year course is offered depending on the qualifications of the applicant. There are regular lectures on such subjects as child psychology, psychiatric theory and group dynamics accompanied by a great deal of practical work. Numerous graduate nurses have taken the course. There are also two nurses who care for the physical health of the patients.

It is intended that the treatment program will be intensive and short, lasting about six to twelve months. However, the time limit is flexible enough to vary with the needs of the individual. When the child has improved enough he returns home if his family conditions are satisfactory. If he is a ward of the Children's Aid he is placed in a suitable foster home. If, after the normal time limit, a patient shows no sign of benefiting from the program he will be sent to another hospital for further treatment.

Thistletown is also being used for research. Long and short term programs are being developed. Data gathered will be available to research workers at the university. In both the research and counsellor training programs Thistletown is paving the way for more hospitals of this kind.

What impressed me most about Thistletown was the new approach which is being taken to this type of mental illness. I found the many original methods and attitudes most interesting and was amazed at their effectiveness. In Britain and the United States there are centres that have been using these methods for several years, but Canada has been far behind. Thistletown, therefore, marks a step forward in the treatment of emotionally ill children.

Greetings from the ICN President

New Year's Greetings to each of you!! It is a joy and a privilege to send a message of good will to our ICN members in all parts of the world.

The past year has been a busy one. We are proud of the progress achieved but concerned about the magnitude of the task before us. We are encouraged by the increased opportunity to be of service but at times frustrated by the limitations of our resources to give that service. However, pride, concern, encouragement, and even frustration can become the stepping-stones to our future success.

As nurses and as citizens the demands and responsibilities for the next year will, undoubtedly, be even more complex. Let us dedicate ourselves anew to the furtherance of our mutual goals — having the courage to extend our programs, the willingness to give ourselves still further, and the faith that we WILL succeed.

Thank you for your loyal support of the ICN during 1959. The ICN will continue to grow in usefulness as we have the benefit of your wisdom, loyalty, and friendship in the years to come. May 1960 bring you a rich measure of personal happiness and professional satisfaction.

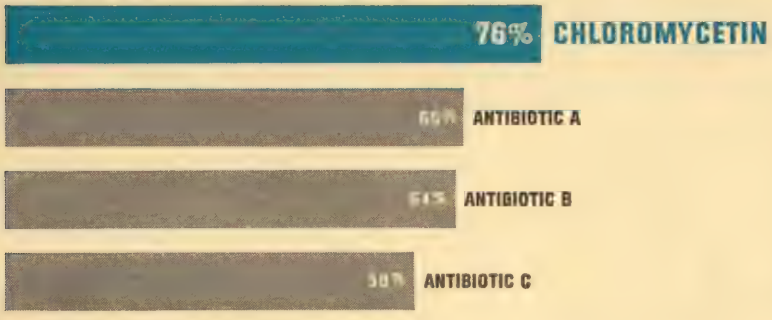
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*Adapted from Leming, B. H., Jr., & Flanigan, C., Jr., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 414.

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In Memoriam

Mrs. Hughena Jean Black who graduated from St. Joseph's Hospital, London, Ont. in 1953, died on February 7, 1959.

* * *

Agnes (Beahan) Cumming, a graduate of St. Luke's General Hospital, Ottawa, died recently.

* * *

Mayme E. (Pritchard) Dinning, a graduate of St. Luke's General Hospital, Ottawa, died recently.

* * *

Margaret Drew, a Nova Scotia nurse who graduated from a Boston, Massachusetts hospital in 1908, died on August 11, 1959. During World War I she served overseas.

* * *

Yvonne Thérèse (Cottreau) d'Entremont who graduated from the Children's Hospital, Halifax in 1956, died recently in a motor accident. She was on the staff of the Faulkner Hospital, Jamaica Plains, New York.

* * *

Jane Grant, a graduate of a Minneapolis hospital in 1899, died on October 4, 1959. For a number of years she was in charge of the social service department of the Toronto General Hospital. Later she worked with the Visiting Nurses' Association in Cleveland, Ohio.

* * *

Blanche Marier, a graduate of Hôpital du Sacré Coeur, Cartierville, P.Q., in 1943, died on September 26, 1959. She had engaged in institutional nursing.

* * *

Mary McKeil who graduated from Victoria General Hospital, Halifax in 1903, died on October 22, 1959. She was charter and honorary member of the RNANS and a charter member of her hospital's alumnae association. Miss McKeil was 82.

* * *

Eleanor McPhedran, a Canadian graduate of the New York Training School of Nursing in 1906, died on October 25, 1959. A former assistant matron of Calgary General Hospital and matron of Ogden Convalescent Hospital, Miss McPhedran served in Canadian general hospitals in England and France during World War I. Following her return to Canada, she was appointed as matron of the Colonel Belcher Hospital, Calgary. Later she became matron of the Central Alberta Sanatorium from which she retired in 1935 to become secretary of the Calgary branch of the V.O.N. She was extremely active in the organization of the nurses of Alberta and became the first nurse to register with the AARN following its incorporation in 1916. She was appointed as the first nurse registrar of the association. In recognition of her contribution to nursing in Canada, Miss McPhedran was awarded the Mary Agnes Snively Medal.

* * *

Mary Margaret (Curtis) Ruddy who graduated from the General Hospital, Oshawa, Ont., in 1941, died during 1959. She had engaged in institutional nursing prior to her marriage.

* * *

Blanche M. Shute, an Alberta nurse and faithful supporter of the AARN, died recently.

* * *

Mary Sim, a graduate of Owen Sound General and Marine Hospital in 1905, died on November 19, 1959. She had engaged in private nursing for many years until advanced age and ill health forced her retirement. She was 85 years of age.

* * *

Sister St. Francis Xavier of the Sisters of St. Francis of Assissi, Hôpital St. François d'Assise, Quebec, died on November 21, 1959. Sister had served as instructor and director of nursing education at Ste. Jeanne d'Arc Hospital, Montreal, and Hôpital St. François d'Assise, Quebec.

* * *

Gladys Lillian (Crozier) Stewart who graduated from Brockville General Hospital, Ont., in 1928, died recently. She had engaged in private nursing.

* * *

Dorothy Eileen (Heinmiller) Swenerton, a graduate of Toronto General Hospital in 1943, died on October 29, 1959, in Kamloops, British Columbia.

* * *

Frances L. (Richards) Watson who graduated from the Hospital for Sick Children, Toronto in 1956, died during 1959. She had engaged in institutional nursing.

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— George Herbert

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Book Reviews

History and Trends of Professional Nursing by Deborah MacLurg Jensen, R.N., B.S., M.A. 610 pages. The C. V. Mosby Company, St. Louis, Mo. 4th ed. 1959. Price $5.25.

Reviewed by Miss Isabel Misener, Director, School of Nursing, Victoria General Hospital, Winnipeg.

In this edition, the author has aimed at a review of historical events and at stressing the widening role of the present professional nurse in society. This has been done in a fine manner. One cannot read the book without feeling that nursing is being placed more and more among the leading "social" professions and that it is being solidly combined with education.

It is important for the nurse to know what the past has been, in order that she can understand the relationships and changes of today. For centuries, nursing and hospitals were outgrowths of charity. It was not until the social outlook changed that a broader view toward the health of the public was taken. The reformation, the industrial revolution, the machine age, the enfranchisement of women, all had an effect on nursing. One of the most important results was the entire reform of nursing education. This book deals primarily with that topic. The dominant figure in the development of professional nursing was Florence Nightingale. She realized that knowledge and skill were necessary and that these could be achieved only by education. At the time of her death, the nurse had professional status, and there was an urgent need for organized schools of nursing.

The period from 1870 portrays interestingly the early schools of nursing, their weaknesses and their aims, the improvement of educational standards, and organization within the profession. The author has pointed out such major changes as the growing awareness of the need for research; the role played by the nurse in community health, and the gradual recognition by governments that nursing education is one of their responsibilities.

The questions and study projects for the individual units are to the point. The section on legal aspects is concise and well-expressed. The graduate nurse is given ample help and suggestion for her planning for the future. The book is a major contribution, and a challenge to us to help in the continual advancement of nursing education.

Microbiology by Louis P. Gebhardt, Ph.D., M.D. and Dean A. Anderson, M.S., Ph.D. 476 pages. The C. V. Mosby Company, St. Louis, Mo. 2nd ed. 1959. Price $5.75.

Reviewed by Sr. Capt. Ethel Kollin, Director of Education, Grace Hospital, Winnipeg.

This book is written to provide a broad general course for university and college students. It could be used with profit by students interested in microbiology as related to public health, sanitation, industry, food preparation and food handling.

The author has produced a very readable book that includes new and up-to-date material. The many applications to everyday living help to stress the practical as well as the scientific point of view.

This book would make good reference reading for a nurses' library, particularly the sections on sanitation, industry, antibiotics and pathogens. The latter is clear, concise and provides descriptions of organisms involved, the mode of disease production and the methods used to detect the causative agent. As a text for nurses I feel that:

1. The application of basic principles to nursing situations is lacking or very brief: for example, provision for and maintenance of aseptic technique in nursing measures to prevent cross infections.

2. Technical material and specific tests occupy space out of proportion to a nurse's need.

3. The sections on public health organization and problems is well written but apply specifically to the United States. There is a very brief history of international organization but no reference to Canada or other countries.

Human Relations in Nursing by Wayland J. Hayes, Ph.D. and Rena Gazaway, R.N., B.S., M.A. 486 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 2nd ed. 1959. $5.25.

Reviewed by Mrs. Hester Kernen, associate professor in public health nursing, University of Saskatchewan, Saskatoon, Sask.

The objective of this book is "to help

nurses gain maximum insight concerning the human relationships involved in professional service." A high degree of skill in human relations is emphasized today as a desirable attribute of the professional person whatever his field of technical competence. This is especially true in nursing which traditionally has held sympathetic personal attention to the patient as a central feature of the professional role. At times the pressure for efficiency in the performance of technical functions has resulted in an impression of lack of warmth in nurse-patient relationships and neglect of what is now referred to as "the patient as a person."

It is believed that one way to correct this lack and to provide a balanced approach to the health and social problems of patients and families is through greater emphasis in nursing education on the use of concepts from the social sciences. This textbook is designed for such use and could be considered as comparable to anatomy and physiology texts which, in the area of biological sciences, provide basic concepts to be applied in nursing practice.

Part One provides an orientation to sociology with illustrations of basic concepts drawn from nursing as well as from previous common experience. Chapter seven — "Society Implies People" — is typical of the style. Demography is presented as a body of knowledge essential to the understanding of problems of health and medical care, and to planning changes in nursing education and nursing service to meet the need of society. A minimum of statistics, based on United States data, is used and is presented in clear, comprehensible tables that clarify the concepts taught.

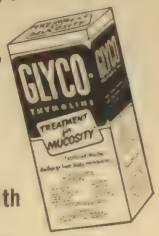
Part Two provides analyses of nursing situations in terms of social factors involved as a means of encouraging a broader understanding both of the patient's problems and community health needs. Community resources to meet such needs are presented as basic principles rather than specific agency programs. Thus the information is directly applicable to any community. This part of the book could be a valuable reference for clinical conferences, the study of community health organization or similar courses.

This could be recommended as a valuable source book for graduate nurses who have not had a course in sociology and who wish to improve their understanding of the world in which we live and work.

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* * *

A comprehensive annotated bibliography, consisting of over 300 references on staphylococcal infections, was featured in the December issue of the *American Journal of Nursing*. Culled from bacteriologic, medical, nursing, and public health literature, the list includes material which should be useful to anyone in the health field with an interest in setting and maintaining standards of asepsis.

A limited number of reprints of the section are available at a cost of 25 cents. Copies can be secured by writing to the *American Journal of Nursing*, 10 Columbus Circle, New York 19, N.Y.

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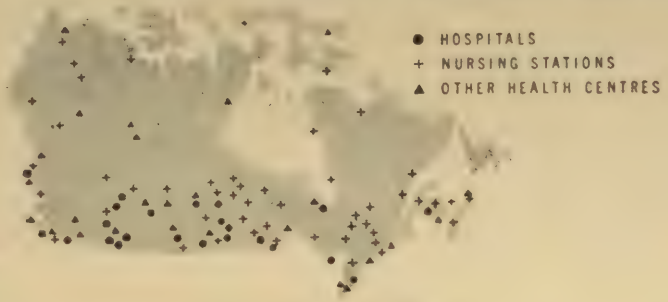
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(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital. Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

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Assistant to Director of Nursing Service to work afternoon & evening shifts rotating bi-weekly, 5-days per wk., in 100-bed active General Hospital. Excellent personnel policies & salary scale. Employer participation in pension plan. Personal interview will be arranged. Forward enquiries to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Registered Nurses for 100-bed active General Hospital. Good salary, personnel policies include 5-day work wk., 14-days paid sick leave accumulative, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan. Apply to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260, Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

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McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

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Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Nurses for 300-bed General Hospital,, basic salary $265 for days, with consideration given to postgraduate & equivalent experience, extra for shift work & call, 5-day wk. 3-wk. vacation after 1-year, 12 days sick leave per year. Apartments available near hospital. Apply to: Director of Nursing, St. Joseph's Hospital, **SARNIA,** Ontario.

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General Duty Nurses, combined Lab. - X-Ray Technician. Salary according to S.H.A. salary schedule & S.S.C.L.X.T. schedule. Apply to: The Matron, Bengough Union Hospital, Bengough, Saskatchewan.

Graduate Nurses for General Duty in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary effective January 1, 1960 $270 or $250 according to registration. 40-hr. wk., 3-wk. annual vacation, 8 statutory holidays, accumulative sick leave. Pension plan available. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Graduate Nurses (2) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 3-wk. vacation, plus statutory holidays, 40-hr. work week. Travel fare advanced if necessary. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses Surgery & General Duty for newly expanded 200-bed hospital located in Southern California. Starting salary $315 per mo. with $10 differential for obstetrics, surgery & night duty, 40-hr. wk. Progressive community near Disneyland. Contact: Director of Nurses, Miss E. F. Horton, Santa Ana Community Hospital, 600 East Washington Avenue, Santa Ana, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Staff Nurses (Openings on P.M. & night shifts) for 440-bed hospital. Starting salary $355 per mo. plus $25 differential. Tenure salary increases. Liberal vacation plan, 7 paid holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. For complete information write: Personnel Office, Sutter Community Hospitals, 2820 L Street, Sacramento, California.

Operating Room Nurses (2 Openings) for large General Hospital. Starting salary $380 per mo., plus $25 P.M. & night differential. Tenure salary increases. Liberal vacation plan, 7 paid holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write to Personnel Office, Sutter Community Hospitals, 2820 L Street, Sacramento, California.

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Registered Nurses for 85-bed voluntary non-profit hospital in growing community of 11,000. Basic salary $295 per mo. with increments of $5.00 every 6-mo. up to 2-years; 40-hr. wk.; 7 paid holidays, sick leave accumulative to 48-days; $17.50 premium for 3-11 shift, $15 additional for 11-7 shift. Apply to: Director of Nurses, St. John's Hospital of Red Wing, Red Wing, Minnesota.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

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Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

General Duty Nurses (2) for modern 34-bed hospital. Salary $235 per mo. plus full maintenance, 3 annual increments at $10 per mo., 1-mo. per year holiday pay, 2-wk. sick leave, 40-hr. per wk. straight shifts. If employed for 1-yr. a refund of train fare from any point in Canada will be given. For further particulars apply to: Municipal Hospital, Two Hills, Alberta, Phone 335.

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Registered Nurse — Salary $295 less maintenance, 44-hr. wk., excellent staff accommodation. 80-mi. west of Winnipeg on No. 1 highway. For further particulars apply to: Mrs. M. C. Roberts, Secretary, North Norfolk-MacGregor Medical Nursing Unit, MacGregor, Manitoba.

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Qualifications — Registered Nurse, supervisory experience.

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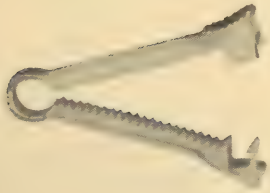


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Change of address: Four week's notice and the *old* address as well as the new are necessary.
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Authorized as Second-Class Mail, Post Office Department, Ottawa.
Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

As a preface to and preparation for the forthcoming biennial convention in Halifax next June, it seemed to the *Journal's* editorial staff that there would be interest and value in providing an opportunity for each of our national committee chairmen to describe succinctly the program her committee had developed during this biennium. The chairmen's replies to our letters of invitation to serve as guest editors in successive issues were prompt and enthusiastic. Sister Mary Felicitas wrote about the nursing service program last month. You can read the comments of Miss E. A. ELECTA MACLENNAN, chairman of the Committee on Legislation, in this issue.

Miss Helen Carpenter is scheduled to unveil some of the problems that have to be considered by the Finance Committee as our National Association strives to match an income based on the per member assessment approved in 1952 against the demands made in 1960.

The least static aspect of nursing in our national scene is the education of student nurses. Two-year programs, plus internship or without it, are very much to the fore. As chairman of the Committee on Nursing Education, Miss Hazel Keeler will make a valuable contribution to your understanding of the whole situation in her editorial in May.

The opening sentence of the foreword to a very useful little book "The Nurse Speaks" by Roy C. Nelson, Ph.D., reads: "The changing concepts of the role of the professional nurse in the hospital, in health agencies, in industry, and as a citizen in the community have emphasized the fundamental importance of the great need for increasing experience in the art and science of communication." If the writer had used "public relations" instead of "communication," the program of our national Committee on Public Relations would have been summed up in that one sentence. Miss Ethel Gordon will gave us her account of her committee's activities in the June issue.

* * *

The application of all of our knowledge of people and their minds, in order to prevent mental illness, is the basic theme of a **mental health program.** Such a program strives to prevent or eliminate crippling emotions and attitudes, to re-adjust unhealthy aims and ideals in order to secure for everyone the fullest potentialities for happiness and usefulness.

None of us can choose our ancestors so each comes into the world with a complex inheritance. Over and above our inborn capacities, everything that ever happens to us, everything we do or think or feel, impinges upon or modifies our personalities, and shapes our destiny to a greater or lesser degree. On the positive side, therefore, we must remember that every person needs to feel that he is loved, that he is important to others and to himself; to feel secure in his emotional relationships, self-confident in his social environment. He must learn to face the reality and perils of his physical environment and to adjust to these unhampered by abnormal fears and anxieties.

Unhappily, psychiatric symptoms occur all too frequently in the rush and turmoil of present-day living conditions. When all of our endeavors to assist an individual to maintain good mental health fail, what then? Most of this issue is devoted to the consideration, by various authors, of how best we may serve our fellows in the preservation of mental health. When the lapse occurs we have an equally important function in seeking the restoration of that health.

* * *

Miss HELEN MUSSALLEM has prepared a brief summation of her intensive work in organizing, conducting and reporting on the first authoritative investigation of the status of a few of the schools of nursing in Canada. No full-fledged evaluations leading to accreditation were made or intended. Rather, it was a preliminary to such a broad program.

After reading Miss Mussallem's summary here be sure that you write for a copy of the full report from your own provincial nurses' association. Just in case you forget the street address (foolish thought!) you will find all of the provincial association headquarters listed in the Official Directory on page 287.

A total of more than 1,600,000 Canadians have received one or more free blood transfusions since the Canadian Red Cross service was established in 1947.

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Manufacturer—Parke, Davis & Co., Ltd., Montreal 9.

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Random Comments

Dear Editor:

In looking over the December issue of the *Journal,* I noted the table of Antidotes on page 1095. I thought it might be of use to bring to your attention the fact that the treatment listed for No. 4, Hydrocarbons, is not recommended by the Poison Control Centre at the Montreal Children's Hospital. As a matter of fact, they are most emphatic that vomiting must not be induced nor the stomach contents aspirated. They recommend instead high liquid intake, and, as soon as hospitalized, chest x-ray, antibiotics and careful observation. Apparently the danger of pneumonia is very great and it is on this that the first aid and medical treatment are based.

E. C., Quebec

Dear Editor:

It was with interest I read the article by Alice C. Mills in the November issue of *The Canadian Nurse,* "The Role of the Nurse Midwife in Great Britain." Since taking a midwifery training at Queen Charlotte's Hospital, London, Eng. in 1937, it has been my regret that Canadian mothers do not have the same maternity service, that all comparable countries have, in the service of a nurse midwife.

The mothers are very safe in the hands of these highly qualified nurses — well trained to deliver a baby when the birth is normal, obtaining prompt medical aid at any signs of abnormalities.

I am looking forward to the time when an article on "The Role of the Nurse Midwife in Canada" appears in *The Canadian Nurse.* Lets have more articles on this important subject.

E. M. H., Ontario

Dear Editor:

Please note the error in the formula on page 24 of the January, 1960 issue in the article "Test Construction in Nursing Education." This should read:

$$L = \frac{80}{9}\left(\frac{x\text{-}m}{\sigma}\right) + \frac{220}{3}$$

Wm. H. Lucow, Manitoba

Dear Editor:

About a year ago, after months of illness in our family, I became depressed and was advised to develop a new hobby. I chose to collect small pieces of silver cutlery from interesting places around the world. I have found the correspondence very interesting but have had a problem finding someone in different countries, for instance Uruguay, who reads and writes English.

I noticed in the December issue of *The Canadian Nurse* in "Between Ourselves" that the *Journal* has subscribers in 103 countries. Could you tell me how I could obtain a list of names and addresses of nurses in these lands. For over a year I have been trying to obtain names of people to whom I could write through our government representatives abroad, missionaries, Rotary Club, and the Friendship Club of England.

Any help will be appreciated.

Mrs. J. L. Ross,
Thornton,
Ontario, Canada.

¶*Perhaps some of our readers in different countries would like to help Mrs. Ross in her search.* Ed.

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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 3

MONTREAL, MARCH 1960

Hast Thou Faith?

When our President took office she gave us the word "Faith" to be our watchword for the 1958-60 biennium. As we near the end of this period we might ask ourselves a searching question. Have we kept faith, with our profession, our public, and ourselves?

I have adapted my title from the New Testament. In Hebrews, Chapter XI and Verses 1 and 3, we read: "Now faith is the substance of things hoped for, the evidence of things not seen," and "Through faith we understand that the worlds were formed by the word of God." I know of no field of endeavor that surpasses nursing for the extent to which achievements and successes are measured through "the evidence of things not seen."

In the field of hospital nursing service we can cite innumerable instances of patients whose recovery can only be described as miraculous. We attempt to pinpoint the reason for these achievements: improved techniques, higher standards, better qualification, more clearly defined functions, a broadening concept of responsibility. But above and beyond all our efforts we sense and acknowledge an Unseen Power supporting our best though meagre efforts — "things not seen."

We are said to be suffering from a wave of commercialism to the neglect of professional idealism and the mission to serve. We do not accept this



(Wright Studios)

E. A. ELECTA MACLENNAN

criticism as valid but we need to look carefully at any of our actions which might have given rise to such a suggestion.

Nursing has experienced a rapid, mushroom growth. This phenomenal growth has brought about many crises of development in innumerable types of situations all at one time so that we have tended to confuse traditional roots with habitual ruts.

As a profession we have endeavored to direct this growth into desirable patterns of professional performance. In the Act of Incorporation of the Canadian Nurses' Association one of the chief objects of the Association is stated: "To dignify the profession of nursing by maintaining and improving the ethical and professional standards of nursing education and service."

The pioneers of modern nursing recognized that if nursing was to survive and develop as a profession fundamentals must be protected, standards determined and maintained. Through legislation, carefully designed and continuously revised to meet changing needs, the nurses of yesterday provided protection to the public from unsafe practices.

We can see many problem areas and acknowledge their grave implications for the future of the profession but with a strong and vigorous profession as our heritage need we fear the future? The General Secretary of the International Council of Nurses has said: "The Past is inspiring, the Future is challenging, the Present is our responsibility." The forward look should be kept. The past is gone except for the lessons it may teach. Neither clocks nor men run backward successfully. The future should be faced with confidence for it promises growth, greater satisfaction and ever-widening opportunities for enjoyment of life and for service to mankind. "Faith is the substance of things hoped for, the evidence of things not seen" and "Through faith we understand that the worlds were formed by the word of God."

HAST *THOU* SUCH FAITH?

E. A. Electa MacLennan
Second Vice President
Canadian Nurses' Association

The humanities, by their very nature, should enter continually into life at every period. If this could be accomplished, our professional nursing students would approach their life work in such a way that they might realize the larger background significances of living. For the humanities have to do with the living of life, and living the good life can be accomplished only by having as an ideal the most complete possible self-realization as our goal . . . this is a high goal and yet if aims are low, achievements are not likely to be high.

The students in a professional school are experienced in practical affairs. They have a gratifying appreciation of actual values. They know when things are valid and not mere entertainment and idle talk. Students want something of real value, something that will command their respect, something they would be willing to use as guidance in life and able to use as a means of adjusting to their place in our society.

Because the students in a nursing school do not usually go on with other English studies they should be given a rich course in literature from the point of view of scholastic philosophy, with a special emphasis on critical principles. These principles, once mastered, may be applied to any imaginative symbolic structure, whether it be a book, movie, radio or television play.

Literature by the very greatness of its scope and by its interpretive and reflective nature seems to be the chief means of learning about our world and about the men in it. When taught in the "wide and luminous view" of the humanities, literature is seen to be as varied and diversified as life itself. The world of poetry and fiction presents to us the world of human beings . . . this critical study of literature confers a blessing of understanding as well as a lesson in the participation of life.

— Clara M. Siggens

* * *

In the seven years since television started in Canada, Canadians have bought nearly 4,500,000 radio sets — 3,500,000 TV sets were sold in the same period.

— CBC Information Services, Ottawa

* * *

Solvency is entirely a matter of temperament and not of income. — Logan Smith

A Community Mental Health Clinic

F. Grunberg, M.D., D.P.M.

The function of such a community clinic is to serve as an educational factor in the prevention of mental illness and as the medium through which rehabilitation can be continued following discharge from hospital.

Community or social psychiatry is one of the new trends in this medical speciality. We are witnessing at present the development of community psychiatric services all over North America and Europe. In the past two years in Saskatchewan two full-time mental health clinics were established — one in Swift Current, the other in Prince Albert.

Mental illness, more than any other form of illness, elicits very strong societal reactions in the community. The history of these reactions and attitudes runs a parallel course to the history of psychiatry as a medical speciality. It can be divided into four phases:

1. The dark age or the phase of *superstition* during the middle ages in which the mentally ill person was not regarded by society as being sick. He was thought of as a sinner, possessed by the devil and deserving punishment. Developing a mental illness at that time carried very grave risks for one's life.

2. Next came a phase of *custodial care* in which society no longer equated mental illness with crime or sin. However, the community did not look upon the "insane" as an individual suffering from disease in need of treatment and care. He was still considered a threat and nuisance. It was expected that he should be removed to an institution where he would be looked after for the rest of his life. Society did not have any therapeutic expectations from these institutions and the medical profession as a whole paid a minimum of attention to this problem.

3. The *hospital treatment* phase is relatively recent. As medical men realized these people were individuals suffering from a disease that was amenable to treatment, a more humanitarian climate developed. The belief grew that patients admitted to a mental hospital had a right to some form of therapy so that they could go back and find their place in the community. However, a complete break with the past is not easily achieved. Society inherits old prejudices that are very hard to kill. Part of this inheritance was the physical setting and economic philosophy of the custodial care phase with the result that most mental patients are still cared for in huge, monolithic institutions, far removed from their families and communities. True, the cost per day per patient remains lower than his counterpart in the general hospital.

It was during this phase that psychiatry developed as a medical speciality, that the concept of the untrained psychiatric attendant was changed to the utilization of the prepared psychiatric nurse, with treatment and return of the patient to the community as the ultimate objective.

Treating these patients in hospital has increased our knowledge and improved therapeutic methods. We know how to diagnose and treat them from the moment they enter the mental hospital until they leave it. We remain very much in the dark, however, as to what happened to each patient during the weeks, months, years preceding admission. We are very ignorant about what happens to him after his discharge until he is readmitted again. With the present methods of treatment, 80 per cent of our admissions can be discharged with some improvement, but we have to face the fact that over 30 per cent of our total intake are readmissions. We do not know why certain patients have to be readmitted and

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Dr. Grunberg is director of the Mental Health Clinic, Swift Current, Sask. This paper was delivered at the convention of the Saskatchewan Psychiatric Nurses' Association last year.

others do not. It is very probable that we shall never find an answer to this dilemma so long as our philosophy remains patient-hospital centered with complete disregard for the patient-community problems.

We have very detailed and accurate descriptions of the evolution of diseases, such as schizophrenia, manic depressive psychosis, in the mental hospital but we have very little data on how those same illnesses develop and evolve in a non-hospital environment. What is not often recognized is that the mental hospital environment, like most other kinds of hospitals, is very artificial, with little in common with ordinary living in a community. It is artificial at the physical level, at the interpersonal level, yet on the basis of adjustment to that environment we very often decide if a patient should remain in hospital or might return to the community.

A new concept in vogue in some mental hospitals, is known as "milieu therapy." Studies of hospitals that have tried to become therapeutic communities rather than custodial institutions have shown that acute behavior disturbances, withdrawal and regression can be considerably reduced by paying more attention to the interpersonal needs of patients and staff. Unfortunately, very little attention has been paid to the question of whether this experence in the hospital therapeutic community has helped the patient to adjust subsequently in his real community, which is by no means necessarily therapeutic. Milieu therapy has definite positive aspects and is undoubtedly preventing secondary deterioration as a consequence of institutionalization but the fact remains that the large mental hospital, totally divorced from the community that it is supposed to serve, is still only a moment in the course of a mental illness. Patients begin to be ill long before they enter the hospital and continue to be ill long after they leave it. We do not yet know the full extent of mental illness in the community.

4. This leads us to the fourth phase in the history of psychiatry: the care of the mentally ill *in the community*. I shall discuss the role and the functions of a community mental health clinic in relation to the mental hospital. Let us first examine the situation in an area with no local outpatient psychiatric facilities that is served only by distant psychiatric wards or mental hospital. The community has to rely on its own resources to cope with five types of problems:

(a) The severely disturbed patient whose deviant or aberrant behavior cannot be tolerated by the community. These patients are usually acutely psychotic and are committed to mental hospital by the family physician and sometimes by the courts. Many of them respond to treatment and are able to come back and find their places in society. There are, however, a significant number of patients who, although symptomatically improved when they leave hospital, relapse within weeks or months and are referred back to hospital. A sort of ping-pong game takes place between the expelling community and the receiving mental hospital, causing a great deal of frustration and discouragement to both.

(b) There are the moderately emotionally disturbed people including the neurotics, the so-called inadequate personality. They constitute a free-floating, unhappy population who run from general practitioners to chiropractors, ministers, social workers, friends, seeking desperately for some form of help. Some are undoubtedly helped by the various members of the community but many are running around in circles from frustration to frustration, thereby causing much unhappiness around them.

(c) Creating much concern in a community are the emotionally disturbed children, the "problem families." Doctors, teachers, social workers and others do what they can to cope with a situation that is often beyond their actual resources.

(d) There are the children and adults who are markedly retarded mentally. Teachers of special classes and public health nurses try to cope with the problem. In the long run, the usual result is that these individuals are placed in institutions.

(e) Finally, there is the psychiatric geriatric problem. Last year 37 per cent of the total first admissions to Saskatchewan's two provincial mental hospitals were patients aged 65 or over. About one-third of the geriatric population accommodated in institutions is in mental hospitals. The establishment of a

few local nursing homes and sheltered accommodations in the community alleviate to some extent this intractable problem, but the fact remains that the mental hospitals must carry a large share, more than the actual incidence of mental disorders in this age group would justify. Many old folks are sent to mental hospitals because they have nowhere else to go.

These are the main mental health problems that any community has to face. Devoid of local psychiatric facilities, the community tries to cope with the problem in a rather disorganized and uncoordinated way. Hospitalization to a distant mental hospital is often the ultimate outcome. A community mental health clinic moving into such an area does not enter a vacuum but rather a "no man's land" between the community and the distant mental hospital. A strategy has to be adopted within the community itself to avoid duplication of services between doctors, public health nurses, social workers, ministers, who are all working individually and often at cross purposes in trying to meet the need. Furthermore, some pattern has to be developed to establish communication and coordinated efforts between the community and the hospitals. I shall concentrate on this aspect of the problem because this is where nurses are most concerned.

There is a question any nurse must ask herself when a new patient is admitted to her ward: "Why has this man been sent to hospital?" Her only source of information apart from the patient, are the two medical certificates which really tell very little. The patient is very often too ill, too frightened in this strange hospital environment, to give any clear account of what happened so questions remain unanswered. The nurse will, of course, do her utmost to make the patient feel comfortable and help him to adjust to the ward. He will be seen by a psychiatrist, who has no more background information than the nurse. A diagnosis will be made and a course of treatment will be decided. Within two or three weeks, when the patient's treatment is well underway, some relative may travel sometimes hundreds of miles to visit him. Usually this takes place during a weekend when most of the psychiatrists and social workers are off duty so the fundamental questions remain unanswered. The patient will improve, will adjust to the ward routine, will participate in occupational activities and, after a while, everybody will be satisfied that he is ready for discharge because he has made such a good adjustment to the hospital environment.

This patient might have been living in a social setting that could have been conducive to his illness and might need some modifications. His family may expect the hospital treatment to achieve a much more radical change in his personality and will not look at his return in a realistic manner. They might not even want him back. These are all fundamental problems that cannot be answered by only observing the adjustment of the patient on the ward. These questions cannot be dealt with adequately when there is no communication between the hospital and the community. The extremely high readmission rate in most mental hospitals is the well known result.

When the Swift Current Mental Health Clinic was established, I became acutely aware of these problems. I considered that the establishment of communications with the mental hospital and psychiatric wards serving our area was a priority task. Short of local psychiatric in-patient facilities, I decided to develop the clinic program to be an active link between the community and the hospitals and to offer the services that the distant hospitals could not undertake.

One of the primary functions of a community mental health clinic is to screen and prevent the hospitalization of mental patients. It has been noted that most patients become ill long before there is any thought of sending them to hospital. At first, the illness is not recognized as such, either by the patient or by his family. External circumstances, which are no more than ordinary stresses of life, are blamed. The patient will be advised "to pull himself together . . . not to worry . . . to take a holiday."

This temporizing will go on until the whole situation becomes intolerable to the patient and his family. When this happens, the community decides that the patient is mentally ill and that

he should be sent to a mental hospital. This illustrates the fact that the social variable is as important as the clinical variable in the hospitalization of a mental patient. A community mental health clinic can, by early diagnosis, intensive outpatient treatment and social manipulation, prevent hospitalization of a mental patient to a distant mental hospital. If, however, the patient has to be admitted to hospital, its staff will be provided with the necessary background information and will be aware of the real issues involved so that the treatment can be conducted logically and comprehensively.

The second important function of a community mental health clinic is the rehabilitation of the discharged or convalescent patient following hospital psychiatric treatment. A word that is often used as a substitute for rehabilitation, and which I find very improper, is "after-care." This implies a very old-fashioned idea that only hospital treatment cares for the mentally ill and that post-discharge attention is something different from treatment and somewhat less important. Thomas A. C. Rennie, a pioneer in social psychiatry states:

> Many years ago a patient reported to me a phrase which illustrated the needs of rehabilitation. Upon his discharge from a psychiatric hospital after months of intensive therapy and restoration to his previous level of mental health functioning, he was advised by his physician: "Now go home and find your niche."

Finding the niche is, in large part, the problem of rehabilitation. The usual treatment process itself gives no guarantee of successful accomplishment of this admonition. As pointed out by Professor Aubrey Lewis:

> Rehabilitation is so much related, in most people's minds, to the hospital inpatient that it is rather difficult to accustom oneself, as I think one must, to the repudiation of any idea that rehabilitation stands for a distinct stage — the post-hospital stage — in the patient's progress back to normal life. I don't believe it does. Treatment must come partly from outside the hospital . . . and must from the outset be guarded and restrained by considerations affecting ultimate resettlement . . . The attempt to distinguish sharply between rehabilitation and treatment seems futile and pointless.

What are then the aims of rehabilitation? They are defined by the National Council on Rehabilitation as "the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." Personally, I feel that this definition is nothing less than the ultimate and most ambitious aim of treatment.

As far as mental illness is concerned, we unfortunately know very little on how to achieve these goals. A complete and comprehensive plan of psychiatric rehabilitation remains to be devised. It is obvious that the mental hospital totally divorced from community action cannot fulfil this function. There is no question that the rehabilitation of the mentally ill can only take place by work in and with the community. It implies a reorientation of our treatment goals and it is definitely more ambitious than removing a set of symptoms and achieving a good level of adjustment to the hospital ward. It has to start as soon as the patient is admitted to hospital and involves everyone — the psychiatrist, the psychiatric social worker, the therapist and the psychiatric nurse. It is obvious that the mental hospital is handicapped when dealing with patients from distant communities but the community mental health clinic, being "on the spot" can serve as the necessary link. It can and it must point out to the hospital treatment team, the area in the patient's behavior requiring modification for his future resettlement in the community. At the same time, it has to modify the social environment while the patient is in hospital and prepare the community for his return. Upon his discharge, an extensive follow-up program has to be applied, with the aim of providing considerable support to the patient and his family. The first few months following discharge from hospital are very often crucial for the future adjustment of the patient.

In Swift Current, we have attempted to apply these principles by establishing a very close liaison with the psychiatric wards and mental hospital serving our area. We have also tried to obtain the cooperation of the local general practitioners in having their

patients screened at the clinic before referral to hospital. The response on the whole has been very good. A large proportion of patients have been seen at the clinic before going to hospital. For all the other cases, the clinic's social worker has made a point of contacting the families shortly after admission and a social history is swiftly forwarded to the hospital. She also visits the mental hospital once a month and holds conferences with the hospital staff regarding the current hospitalized patients from the Health Region.

In brief, the clinic staff works intensively with the families and community while the patient is treated in hospital. Upon discharge, every patient with his family automatically receives an appointment to attend the Mental Health Clinic. If the patient cannot travel, an initial post-discharge home visit is made by the clinic's psychiatric social worker and, if necessary, by the psychiatrist. After this initial assessment, it is decided whether the case should continue to be followed by the clinic or referred to the district public health nurse who will keep the clinic posted on the patient's progress, or early signs of relapse. Of course, the privacy of all patients is respected. A few have refused to maintain contact with the clinic, but those instances are very rare.

This program is still at an early stage and proceeds very empirically. There are, however, some encouraging indications that the readmission rate in the Region is decreasing while the discharge rate is increasing. This strengthens my conviction that psychiatric treatment has to be given at the community level. Coordinated efforts between the mental hospital and the community mental health clinic are not only desirable but a must.

Illness and Applied Psychology

Sister Joseph Ovide, f.c.s.p., M.A.

Here is a searching look at illness. What nurse has not spent, at least a few moments, with like thoughts?

Illness represents a human conflict. One might say that it dates back to the beginning of creation and the departure of man from the Garden of Eden. It is a form of individual conflict, a drama that plays itself out in the human being who has come to grips with illness — an unique experience for each one of us. Sickness then is a form of human and individual conflict that reflects upon the physical and emotional integrity of the person.

According to A. Cuvelier[1] doctor-psychologist, modern occidental man is particularly sensitive to the effects of illness. He accepts the progress of aging and the inevitability of death with great difficulty. The same author maintains that modern man seeks escape from himself and his fundamental, intrinsic spirituality, that he seeks an existence in the lives of others. Withdrawing from his inner self, he becomes the slave of people and things around him and finds his reason for being in collective activity. Looked at in the light of this, illness with its enforced isolation and inactivity can lead to genuine personality disintegration. The subjective impressions of having been crushed and made lesser can awaken feelings of insecurity, frustration, even guilt. These complex feelings will serve to promote emotional conflict.

In the system of emotions, the two poles are anger and fear. Anger induces aggression, attack, movement towards an adversary, while fear makes the individual withdraw into himself.

Sister Joseph Ovide is director of the school of nursing, Verdun General Hospital, Montreal.

There is movement involved in fear as well, but it is one of recoil, with a vague personality break-up. As a result we encounter two behavior types in the emotionally ill. On the one hand there is aggressiveness or a sort of questing as the individual seeks for love and protection. He may even use rudeness, violence or similar measures since they attract attention. In contrast fear tends to result in avoidance of contacts with the individual taking refuge in solitude, daydreaming or even illness.

Fear, anxiety and obsession are manifestations of mental distress. They are defense mechanisms. Through such a mechanism, the patient introduces a point of least resistance into his personality which may be pierced by an outburst of distress as he first becomes conscious of a threat to his ego.

The type and the origin of mental distress varies according to the existing lines of strength of the individual psyche and the diverse conditions affecting the patient emotionally. More precisely, the fundamental types of mental distress — hardship, neglect, mutilation, conscience give rise gradually to more advanced forms. Primary forms are aroused throughout the course of life in situations that involve separation, hardship, illness, abrupt change to a new life. It is as if these situations touched a chord in the confused memory of the individual related to early emotional trauma.

Nervous tension, that brings about the conflict of illness, monopolizes all or part of the emotional resources of the individual. Under the pressure of irrational forces he automatically reacts through the various defence mechanisms. These mechanisms, if unanalyzed and uncontrolled, can cause the patient to regress to an infantile stage. Such regression opposes progress and fosters mental retardation. It hinders full development of the personality. On the other hand, the emotionally well-developed individual puts his reasoning powers into action to help him face reality, analyze its meaning and gain control over it. Defence reactions in this instance are quickly transformed into conscious, reliable, acceptable and objective behavior as the result of reasoning and confidence. In the well-adjusted personality the conflict of illness does not become deeply rooted since it is only a passing phase. The ego, in conformity with the laws of nature, gradually rises again, unified and whole.

The Attitude and the Role of the Nurse

The nurse with the patient must be free from personal conflicts. Her own suffering and failures must be resolved; her anxieties and passions well-controlled. She must be free from egocentrism so that she can accept the patient as he is, believe in his worth as an individual, and in his own estimation of his responsibilities towards himself, and others.

The nurse must possess the following traits in addition:

1. *Emotional maturity:* She must be capable of objectivity. She must be able to meet and accept others as they are. She must help the patient to attain a greater degree of healthy maturity, but without expecting too much from him since illness sometimes weakens the ego.

2. *Sense of values:* The nurse with a true sense of values will never neglect the person for the benefit of technique, spiritual well-being for material well-being.

3. *Self-fulfillment:* The nurse's personal sense of fulfillment is the mark of a personality that has achieved satisfying sublimation of anxieties.

4. *Competence:* The nurse must know how to profit from study and from experience. She must keep an open mind to the discoveries of contemporary psychology. The variety of information and the efforts being made towards correlating it can assist her greatly in understanding her patient and in caring for him. We must remember however that psychology can not explain human nature completely and its theories must not be taken as final certainties. Unquestioning acceptance in this field would be as unfortunate as scorn or indifference. True learning points the road to wisdom, to temperateness and humbleness, and this, in turn, leads to a deeper understanding of the human being.

5. *Prestige:* The nurse needs authority but it should be acquired in recognition of superior ability — the only true source of prestige.

6. *Desirable Attitude:* It is extremely important that the nurse should have a

healthy, objective attitude towards the patient. Recent scientific research by Stoller and Geertsma[2] confirms this and demonstrates most effectively the unfortunate results of negative attitudes in doctor-nurse or nurse-patient relationships. The study was carried out on a group of students in psychiatric medicine. It showed that the students were very much interested in the theory of mental illness but their anxiety increased in proportion to increased responsibility for and contacts with patients. It was then that the doctor-nurse relationship became crucial and tended to produce emotional responses inappropriate both professionally and scientifically. Subjective reactions composed of anxiety, negative attitudes, rejection and blame prompted the student to *judge* rather than *evaluate* the patient's condition. Their projection mechanisms prevented objective, positive thinking.

The nurse's basic attitude, then, is of prime importance. It is developed out of respect for human worth. More specifically, in the face of agressive behavior, she must avoid an aggressive response since the patient is really seeking understanding. In this respect demands may be made upon her to which she obviously cannot accede in order to avoid an over-emotional attitude on the part of the patient that may emphasize his tendency to regress.

When the patient's attitude is one of withdrawal from reality, the nurse must avoid showing coldness or indifference in order not to intensify this. She will see to it that the patient is kept in touch with everyday events, that he is on good terms with his family and friends. This serves to build up his feeling of security. A sincere interest in the patient, an accurate estimation of his worth as a person and tolerance of his tyrannical behavior will most often be the best response and most effective remedy against feelings of frustration.

To what source can the nurse look for help in developing this ideal attitude, this genuine unselfishness and true poise? Valuable as psychology may be, it can not replace the spirit of true love in accepting and serving our patients. This is the only possible answer.

Reference

1. *The Journal of Medical Education,* Vol. 33, No. 8, p. 585, 1958.

We all wish to be loved alone . . . Mutuality is the essence of love. There cannot be others in mutuality. It is only in the time-sense that it is wrong. It is when we desire *continuity* of being loved alone that we go wrong. For not only do we insist on believing romantically in the "one-and-only" love, mate, mother . . . we wish the "one-and-only" to be permanent, ever-present and continuous . . . There are just one-and-only moments. To return to them, even if temporarily, is valid.

The pure relationship is limited in space and in time. In its essence it implies exclusion. It excludes the rest of life, other relationships, other sides of personality, other responsibilities, other possibilities in the future. It excludes growth . . . One learns to accept the fact that no permanent return is possible to an old form of relationship; and more deeply still, that there is no holding of a relationship to a single form . . . Because it is not lasting, let us not fall into the cynic's trap and call it an illusion. Duration is not a test of true or false. Validity need have no relation to time, to duration, to continuity. It is on another plane, judged by other standards. It relates to the actual moment in time and place. What is actual is actual only for one time and only for one place.

— *Gift from the Sea,*
ANNE MORROW LINDBERGH

* * *

Such truth as opposeth no man's profit or pleasure is to all men welcome. —HOBBES



The Canadian Red Cross will have to collect 500,000 bottles of blood in 1960 to meet transfusion therapy demands of Canadian hospitals.

The Child is Mentally Retarded

HERO DE GROOT, M.D. *and* BREG DE GROOT

This is the story of parents, by parents — for nurses. It is the story of their problem and how they are coping with it. They are not alone with it nor did they cope with it alone.

IN 1947 we became the very proud parents of twin boys. We already had a girl, almost three years old and you can imagine how happy we were with those two little babies!

As is the custom in Holland the children were born at home. Only when the doctor expects complications is the delivery done in a hospital. We did not expect any complications. We were even completely unaware of the fact that two babies were on their way instead of one. The boys arrived one month too soon and were rather small, one five pounds, the other only three. There was no nurse; no time to put the kettle on the stove. We did the delivery ourselves, then called on the neighbors for assistance. We telephoned for a taxi so that the smaller baby could go to the hospital to be put into an incubator.

When all these details had been looked after we settled down and enjoyed a good laugh. In this lighthearted way began the biggest "thing" in our lives. Two days later the smaller boy developed such severe convulsions that no one expected him to live. When he did recover it was obvious that he would not be normal, that his brain had been severely damaged. How retarded he would be we could not know.

What helped us most during the first difficult days was that everyone accepted our little boy as just another baby. It was a great moment when the matron of the hospital in which we worked entered the room with a huge basket full of baby clothes, food and flowers. She, like everyone else, considered the event a very happy one and had come to rejoice with us. We did not sit down to discuss what would happen to him eventually; how mentally handicapped he would be. Nobody mentioned the fact that at some time we might have to put him in an institution. In short, we did not try to live his entire life and foresee all future problems at once. He was our child, just like the other two — to love, to cherish, to feed and to keep clean.

This is the point at which the doctor and nurse can be of much support to the parents. It is a deep sorrow for all parents when they have a child who will never leave the parental home to start a life of his own and to continue on the road on which they have given him a start. On the contrary, his life is the end of the road. For him, many of the dreams we normally have for our children will not come true.

In realizing this, parents tend to feel that their own world has come to an end. They do not know how to cope with all of the many problems they foresee. They want to solve them all at once. The nurse can do for them what the matron and many others did for us. She can reassure the parents that they do not have to solve all of these problems at once. They can give their baby what he needs at this moment.

This does not mean that we should never sit down to discuss a long range program for the child who has special needs, but it need not be done right at birth. The nurse can do so much for the parents to help them to feel at ease with their child. Through the nurse's attitude parents receive fresh courage to give this child all of their love, strength and wisdom so that he too may grow up to live as useful a life as he is capable of doing; to do his share of the work of the world, a very

Dr. de Groot is a practising physician and surgeon in Regina. Mrs. de Groot, was engaged in social welfare in Holland. She has had to overcome many obstacles in order to establish the Harrow de Groot School for Retarded Children in Regina.

modest share maybe, but a necessary one. Whatever the future holds for him does not change the fact that he is, right now, only a baby with the same needs as all other babies. He may not be very strong physically; he may need a different kind of formula and all kinds of special care. Our little boy was completely encased in a cast for a year so that his back would grow straight. In most cases the care is such that parents are capable of giving it and should be encouraged to do so because the child is entitled to it. We have no patience with those who advise parents of a Mongolian child, for instance, to send him to an institution as soon as possible after birth so that they will not become too attached to him. As if attachment had not started nine months before!

As doctors and nurses it is our job to fight disease — to "do something about it." We try to cure. Acceptance without fight is foreign to our nature. Although we have to accept this child the way he is, we do *not* have to accept the fact that so many children are born or become mentally handicapped. Because we do not accept this fact, more and more research is done. Parents who are unsatisfied with the lack of educational and recreational facilities for their children get together and "do something" about it.

The acceptance of the child the way he is, with his limitations and his possibilities, brings with it the acceptance of all the many difficulties that will occur as he grows up, for example, the type of school for their child and his later years spent, perhaps, in an institution. When the child does not make progress in school, some parents are convinced that he does not want to work. They need to be helped to accept the fact that it is not a lack of will but rather that the child cannot do the work. So often the parents of a retarded child force him into the harness of behavior and abilities of an average child, force him toward achievements of which he is not capable, thus doing irreparable harm to his development. The only way to further the development of the child is to allow him to grow up under the most favorable and most suitable circumstances in other words — allow him to *grow up along his own lines.*

Although retarded children have many different needs, they have one that they share with all mankind — to be wanted and to be loved the way they are. We older, more sophisticated people learn to accept the fact that we may be loved for the accessories we have acquired through life — wealth, position, etc. These children do not realize this and they feel rejected. There are many forms of rejection and this hurts them more than anything else.

Although she is not trained to deal fully with this great problem, the nurse can be of assistance in her contact with parents. She can help them to overcome false shame. She can point out what can be done. She can inform them of how they may obtain professional assistance. Only after very extensive examinations have been carried out can a suitable course be planned for the child.

Some parents are not content with the point of view of one doctor and have the tendency to "shop around" for other opinions. This is often frowned upon by the medical profession. However, in many cases it helps the parents to adjust themselves slowly. As long as it does not ruin them financially, it is one means of easing their consciences because many parents struggle with feelings of guilt. The sooner the parents are able to accept the fact that this child will develop at a much slower rate than other children and will need special guidance, the better it is for the child. It is not for us to condemn parents for what appears to be a lack of confidence in their doctors. We should support them and help them to find security in the judgment of their medical and other advisers.

There are many books, pamphlets, films, etc. in which parents, teachers, nurses and others can find extensive information on all aspects of retardation. There are also many excellent books on home training, for example, "You and Your Retarded Child" by Dr. S. Kirk.

The nurse herself needs to be aware of what is being done for retarded children in her own community and elsewhere. There exists in Canada a national association for retarded children which has provincial and local

chapters. In Saskatchewan, for instance, the provincial Association for Retarded Children organizes seminars for parents of retarded children who live in rural areas of the province. This provides an excellent opportunity for parents to become better acquainted with the facts of retardation, to observe different techniques and last, but not least, to meet other parents who are facing the same problems.

Earlier in this article it was mentioned that we do not readily accept the fact that so many children are born mentally retarded or become retarded. Most of the research on mental retardation is done in the field of medicine. The program is extensive. More and more, the importance of keeping detailed prenatal and obstetrical records is stressed. This is a field in which the nurse can be of great assistance. The United States Public Health Service is undertaking a five-year study of 40,000 pregnant women in an effort to find the cause of cerebral palsy, mental retardation and other birth injuries. Although so much still needs to be done progress is being made.

A specific type of mental deficiency, that is usually severe and is called "phenylpyruvic oligophrenia" (phenylketonuria, P.K.U.) is diagnosed by a simple paperstrip test (Phenistix). This mental condition is associated with a metabolic error that, recent studies have shown, can be corrected by a restricted diet. Most of the children whose diagnosis is made early and who are placed on a special diet within the first two years of life, improve and show more or less normal development. In order to diagnose this metabolic disorder before the harm is done, many hospitals and well-baby clinics now include this very simple urine test routinely in their examinations.

This is just one of many new developments and must serve as an example of how important it is to be aware and up-to-date, so that human suffering can be prevented.

In the Good Old Days

(The Canadian Nurse, MARCH, 1920)

Caring for the Sick Poor

In spite of the remarkable development of hospitals and training schools, there has been constantly before us an unsolved problem in nursing which is becoming more pressing each year — that of providing care in the homes of the poor and the people of moderate means.

The real difficulty lies in the fact that our government system is faulty in so far as it relates to the care of the poor and the sick . . . It is not a system of justice — the majority of our charitable organizations and hospitals must be maintained by private philanthropy.

Is it not possible that the answer lies in organization and inauguration of a system of home nursing on a large scale, which recognizes the trained nurse of present high standards, or even higher, as an essential factor, and supplements her by the employment of experienced assistants and household workers?

This idea has been tried with conspicuous success in several cities, notably Detroit . . . The hospitals are always available and desirable for those who are seriously ill. This system, carried out on a large scale adequate to the size of the problem, seems at the present time to be the best solution.

* * *

Registration of Graduate Nurses

Another province has been able to get legal recognition of the profession by succeeding in passing an Act for the Registration of Graduate Nurses. Quebec is the latest to get this . . . Now all Canada, with the exception of Ontario, Nova Scotia and Prince Edward Island, has an opportunity to standardize their schools and to insure the public that when they employ a registered nurse, she has had a proper training and should be capable of good work.

Years of love have been forgot in the hatred of a minute. — EDGAR ALLAN POE

* * *

Worry, the interest paid by those who borrow trouble. — GEORGE W. LYON

Mental Health and Maternity Care

ESTHER J. ROBERTSON, M.A.

A new life is on its way! How this person-to-be will develop is influenced physically and emotionally months before he makes his debut. Nurses are one of the most important of the influencing factors. How do we meet the challenge?

GOOD maternity care means more than medical and nursing services which have as their objective a live mother and baby. It means services planned to promote the physical, mental and emotional well-being of mother, baby and family. Scientific research and refinements in maternity care have reduced many of the physical risks involved in child-bearing. When adequate medical services and facilities for obstetrical care are available, the modern mother usually ends her pregnancy in good physical health. This is an important objective but it is not enough unless good mental and emotional health are also included. How may we as nurses help the mother complete her pregnancy with confidence and satisfaction as well as with safety? Are we providing her with the care, the information and the type of support she needs?

Fortunately within recent years, the mental health of the mother has been given more consideration. There is increasing recognition of the fact that mental and emotional reactions to childbearing and motherhood may influence the physical course and outcome of the pregnancy. What the mother thinks and feels has a great deal of significance for nursing during the maternity cycle. The birth of a child is one of the events of life that can be described as trying. Pregnancy creates stress. It may become

> a crisis for those individuals who by personality, previous experience or other factors in the present situation are especially vulnerable to this stress and whose emotional resources are taxed beyond their usual adaptive forces.[5]

Miss Robertson is nursing consultant, Child and Maternal Health Division, Department of National Health and Welfare, Ottawa.

The mother's ability to adjust to her pregnancy and its stresses, and the way in which she adjusts will depend upon the understanding support she receives from her family and the type of maternity care she receives. As we work with the mother, the family and the doctor, we have the responsibility of contributing to the mental health of the mother and her family. In order to do so we need to be aware of the total health needs of the mother.

> Factors operating on the biological plane in the expectant mother interact reciprocally with factors in her psychological functioning and in the interpersonal relationships of her family group.[2]

The Prenatal Period

Although pregnancy is a normal physiological function, individual mothers vary in their reactions to it. Our knowledge of the normal reactions that are likely to occur will help us to interpret them to the mother and family. Most mothers have ambivalent feelings when they know they are pregnant. She may vacillate between happiness and unhappiness, be depressed or elated. Mood changes are to be expected as she contemplates the responsibilities of motherhood and wonders about her ability to meet them. As her body reacts to the changes in hormone balance, so do her thoughts and feelings, especially during the early part of pregnancy. She thinks of her loss of freedom, of possible changes in her relationships with her husband, of sharing his love with a child. She thinks of expenses involved for her own care as well as for equipment and supplies for the care of the baby. She thinks of the process of labor, often with fear and anxiety.

On the other hand, the mother may think with pride of the ultimate fulfillment of her female role — the bear-

ing of a child. However, despite her periods of joy and pride, she may be difficult to get along with since she finds it hard to understand her own mixed feelings and reactions. Because she cannot understand herself, she thinks that others fail to understand her. It is not unusual for a prospective mother to experience inexplicable periods of sensitivity and irritability. Her feelings may be easily hurt, her temper short.

As pregnancy advances the mother's thoughts become introspective. She may become demanding of affection and attention from her husband and family. Caplan[2] explains this reaction as the possible need of the mother to increase her supplies of love and affection so that later she will be able to pass them on to the baby.

Throughout pregnancy the mother thinks of her own safety and that of her baby. Most mothers build up tensions, anxieties and fears with which they need assistance. All mothers have impressions, ideas and attitudes about childbirth that are related to their cultural, social and educational backgrounds. They have heard accounts of childbirth experiences. Mothers, like all human beings, fear the unknown. By encouraging them to express their thoughts and feelings, by listening carefully and by providing them with information as the need arises, we are able to promote good mental health. The mother who has a knowledge of physiology and the process of labor is more able to overcome her doubts, fears and anxieties as the end of her pregnancy approaches.

To illustrate these normal reactions to pregnancy let us consider Mrs. Barton, an attractive, 20-year-old primipara. She had been married three years and was six months pregnant. Her maternity care was being provided through the outpatient service of a large urban hospital. She appeared shy and reserved on first acquaintance and had difficulty in sharing her thoughts and feelings with anyone other than her husband and a younger sister. Knowledge of her fears, anxieties and attitudes toward pregnancy was gained first from her husband and later directly from her.

Mrs. Barton's sister had had two children, both by Caesarean section. She was therefore unable to share the experience of a normal labor and delivery and Mrs. Barton was too shy to admit her lack of understanding. She said she was "prepared to stand the pain when the time came." Because of her attitude Mr. Barton felt that his wife did not want to have a baby. He thought that she felt "trapped" and because of this was not a bit like her usual, happy self. Some days she said she was looking forward to having a child, on other days she was sorry she was pregnant.

In time Mrs. Barton was able to talk more freely about her pregnancy to the clinic staff. It became apparent that she wanted to have a family. The warmth of tone in her voice when she discussed her small niece and nephew implied that she loved children and wanted a baby of her own. Basically, she feared labor and separation from her husband. When she learned that he could be with her in the labor room, she became less apprehensive. As she began to understand the meaning of labor and the physiological process involved she became interested in the simple breathing exercises and positions of relaxation that she could use. Together, she and her husband planned for their baby with confidence and understanding.

The support and encouragement of her husband is important to the prospective mother's adjustment and to her mental and emotional health. If she is secure in her husband's love, she is more likely to think of her coming baby with pleasure and eager anticipation. She is able to think of motherhood with a more realistic approach as her confidence in her own ability and her trust in those providing her care develops.

The Nurse's Role

The nurse is in a position to help parents plan for the coming baby. She provides the background information to ensure that the birth of their baby may be anticipated with confidence. She assists them in avoiding some of the tensions, strains and frustrations of daily living by helping them to understand the physical changes that are taking place in the mother, her need for rest and an adequate diet. The nurse may guide and encourage parents toward independent action as they work out plans and make decisions related to their needs.

There are some mothers who need *special* help during the prenatal period. These include the unmarried mother, the mother who has lost her husband through death or separation after conception, and the mother whose attempts at abortion have failed. The mental health of these mothers may be in a precarious position. The counselling skills and abilities of the nurse are of utmost importance. The nurse can make a worthy contribution if she is free from prejudiced personal opinions; if she listens carefully and tries to think through the situation from the other person's point of view; if she refrains from prying and probing; and finally, if she can recognize when a problem is beyond her scope. Then she can assist the mother to obtain the help of a specialist.

Many of these mothers have complex social problems. Often, they fail to seek medical care and need help in obtaining it. Team work between doctor, nurse and social worker is essential so that support, understanding and scientific information become available to the mothers. They have the same basic need for reassurance through relief of doubts, fears and anxieties as all pregnant women. Their special problems make their adjustment more difficult. An adequate discussion of the nurse's role in providing maternity care for mothers with these special problems, would require separate detailed consideration, but the basic principles for promoting mental health through information, understanding and support are the same for the maternity care of all mothers.

Labor and Delivery

The mother who has had the opportunity to express her thoughts, her doubts and fears; who has had her questions answered; who has received information to prepare her for labor and delivery should enter hospital with no more apprehension than anyone has in a new situation. She is in a strange environment that is symbolic of illness. She is not ill but rather has come to hospital to fulfil a normal physiological function. Her thoughts centre around her baby and her ability to deliver it. She expects help and support. She tries to remember what she has learned about labor and what she is expected to do.

From the moment the mother enters the hospital, the nurse has a supportive role to play. She has an opportunity to meet the mother's mental and emotional needs, while she attends to her physical needs. Explaining procedures, informing the mother of her progress, helping her to relax, encouraging her and answering her questions are some of the ways in which the nurse may contribute to mental and emotional well-being. In some hospitals the husband who wishes to do so, is encouraged to remain with his wife in the labor room. The nurse is in a position to help them make it a satisfying experience. A husband is able to provide support if he knows the role he is to play and if he feels secure in it.

As labor progresses the mother become very dependent on the doctor or nurse for the kind of support that will ensure a satisfactory experience for her. With the newer philosophy of obstetrical care, more mothers are able to participate with conscious effort during the final stage of labor and delivery. Care should be taken that comments and discussions are interpreted to the mother so that she understands. Unnecessary mental anguish may be caused by thoughtless remarks.

Conscientious planning by the nurse is necessary to safeguard the mother's dignity, to preserve her modesty and to reduce her feelings of dependency as much as possible. Supportive care means care provided by

> an understanding nurse — a nurse who asks herself, what would I want if I were in this woman's place? — and then does what her judgment tells her she herself would want. This is empathy — *experiencing with* — as contrasted with sympathy — *feeling for.*[4]

Following Delivery

Immediately following delivery the mother will want to see her baby. Often the first look at the newborn is a shock for which the mother needs to be prepared. During pregnancy she has thought a great deal about her baby. In all probability she has formed a mental image of what he or she will look like. Even if she has been told what a newborn does look like, she may still be disappointed. She needs

to know that his unsightly appearance is temporary.

The mother may think of her baby as a stranger and find it difficult to establish a relationship with him. During pregnancy she may have thought of him as part of her body, something unseen. In her state of fatigue following delivery or early in the postpartum period she may again experience an overwhelming fear of the responsibilities of motherhood. There may be a feeling of rejection of the baby when she thinks about the burden and cost of care and the sacrifice of personal freedom.[7] She needs help with her adjustment to her baby and to a new way of life. Aware of her own disappointment in the baby's appearance she may wonder how her husband will feel when he first sees it. Future parent-child relationships may depend upon the understanding support the nurse is able to give to the young parents as they become accustomed to the new member of their family.

Parents whose baby is born with a congenital malformation, require a very special type of professional assistance, support and counselling. The nurse's role is influenced by the severity of the malformation, the doctor's relationship with the parents and the role he plans to play. The parents, doctor and nurse work together to plan for the future of the baby and family.

Getting to Know the Baby

During the postpartum period the nurse will anticipate and then help the mother to cope with the "letdown feeling" that is likely to occur. The mother may be disappointed in her "motherly feelings" and find them different from what she thought they would be. The nurse may discuss with her the fact that maternal love is something to be learned.

> 'Maternal instinct' develops with encouragement and with experience as the mother learns to care for her child. Assisting the mother to develop competence and confidence in her ability to care for her child helps her to become independent and to face reality.[6]

Where rooming-in is provided, the the mother is able to have her baby in the room with her for most of the day. She has an opportunity, with the help of the nurse, to become better acquainted with him. She learns his habits and gains satisfaction from participating in his care and in making him comfortable and content. The father too has an opportunity for closer relationships with mother and child. Gowned and masked, he may handle the baby and get accustomed to him. Often, the father is the one who gives the mother the special type of support and encouragement that she needs so badly as she is learning to love her baby. The parent-child relationship fostered under these circumstances contributes to the future good mental health of the whole family.

The choice of a method of feeding the baby may be a point of conflict for many parents. During the prenatal period the mother may decide whether or not to breast feed. If she does decide to breast feed, she will need considerable support and encouragement as she and the baby learn the technique involved. Successful breast feeding fosters strong identification between mother and child and helps promote the feeling of "motherliness." On the other hand, failure in the attempt to breast feed causes feelings of inferiority, discouragement or guilt. Whatever the method of feeding, the mother's feelings affect the baby. If the baby fails to gain satisfaction from his feeding experience, both mother and baby become tense and anxious. If the feeding experience gives satisfaction, the baby and mother interact with harmony.[1] Nurses are in a position to provide the information and assistance needed to make the feeding experience a satisfactory one.

Taking the Baby Home

As the nurse helps the parents prepare to take the baby home, it is well for her to remember that there is no *one* way of caring for a baby.

New parents often think that their inexperience will harm their child. They do not know that love rather than skill counts. Helping them to understand that their baby will respond to their love and care with a sense of trust and a feeling of security will reassure them. Parents need to know that this basic trust and security is the foundation for their child's future good mental health.

The degree to which parents can provide the material things of life varies with economic circumstances, but, family relationships that build and promote a healthy type of family life may be achieved in any home. There is no price tag on love, trust, respect and faith nor on parental guidance, as the child learns to take his place within the family group. These are the essential ingredients of good mental health. Adult mental health is based on childhood experiences. There are no limits to the contribution that a skillful, understanding nurse may make through the maternity care she provides. The opportunities are many and varied. It is our responsibility to recognize and use them with wisdom and skill.

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The Public Health Nurse and Mental Hygiene

NOREEN PHILPOTT

Is the concept of public health synonymous with physical health? If it is not, then does the present application of this concept include promotion of mental health and prevention of mental illness?

HAVING passed through the heroic era of medicine with its haphazard methods of diagnosis and treatment, through the anatomic age when the mysteries of the human body were first revealed, and through the era of bacteria initiated by Lister's theories on asepsis, we have now reached what may be termed "The Age of the Psyche."

Psychiatry has become recognized as a science in itself while the treatment of the mental as well as the physical manifestations of illness has developed into the study of psychosomatic medicine. Going back in history, we see that the search for a treatment of a disease usually far preceded the search for a way to prevent it. Today, the prevention of mental illness is one of the foremost subjects of concern.

Miss Philpott is a public health nurse with the Victorian Order of Nurses, Burlington, Ontario.

In spite of the increase in the numbers of patients discharged per year, our psychiatric hospitals continue to plead for larger quarters. The flow of drug addicts, emotionally disturbed individuals and those who are mentally retarded appears unending. This has emphasized the need to seek the causes for these deviations from the normal and has necessitated the formulation of certain criteria for mental health. To some, the criterion would be merely an absence of mental disease. This is comparable to the description of wealth as being the absence of poverty. Mental health must be an optimum state composed of factors which contribute to and maintain a truly balanced personality in the individual in society.

What are these factors? The first is an understanding and acceptance of "self" — the physical, emotional, and intellectual states. This implies living within the limits imposed by one's body while endeavoring to main-

tain good physical health. *Mens sana in corpore sano.*

The acceptance of the emotions of joy and pride does not entail the difficulties that often ensue when one attempts to reject or ignore the more unsavory feelings of guilt or hatred. The latter may result in the utilization of mental defence mechanisms. We rationalize our behavior to try to exclude these expressions of inner turmoil from the conscious mind. When such attempts become too frequent or too extreme, the balance essential to optimum mental health is disturbed. This disruption of the personality equilibrium may affect not only the emotional patterns but also the entire philosophy of life of the individual.

Just as our emotions deeply affect our actions so do our thoughts and attitudes. This must be recognized and accepted if we are to see ourselves as we are and so become capable of honest criticism of our emotional well-being. We also need recognition and acceptance of intellectual ability. To judge one's innate capabilities by the results of an intelligence test or an academic examination is not sufficient. The endowed powers of accomplishment are rarely utilized to their fullest and are too often channelled in inappropriate directions. One should strive to learn his own limitations and work to the best of his ability.

The second factor is the acceptance of others — not with mere tolerance but with the sincere desire to understand them. This is essential to man who, as a social being, exists not alone but with others and develops his own personality, at least in part, through interaction with others. To truly accept someone else as he is, one must first be conscious of one's own emotions and attitudes and realize that others are capable of experiencing the same problems, aspirations and failures as oneself.

Finally, one must have a philosophy of life based on a belief in something other than himself — a Supreme Being, a way of life. The form which it takes is individual but the need for such a belief is universal. To exist *by* one's self *for* one's self is impossible. Man alone is too frail a foundation upon which to build personal security. The goals that we set are not the most important consideration. It is the manner in which we strive toward them that is of consequence. The Bible shows us the way to be acceptable in God's sight; the ideals of democracy demonstrate the path to freedom; the ethical code of a profession gives its followers the instruments with which to gain an acceptance and an understanding of the true meaning of success in that field. Thus, to believe in something which we ourselves are not but which we plausibly could be is important in attaining the balance between success and failure — a balance so essential to mental health.

What is the responsibility of the nurse in the field of mental health? She must cultivate healthful attitudes toward her own emotions and actions and also toward those exhibited by others. Once she can recognize and honestly accept the concept of mental health, she may then act in her capacity as a teacher to help others to attain it. Do our schools of nursing fully prepare the fledgling nurse for her responsibility in this sphere? The instructor who does not realize the need for giving support to the shy student who finds it difficult to talk with her superiors is not exhibiting good mental health techniques. The young girl who has been relatively sheltered in her own family group and who is suddenly faced with the responsibility of caring for critically ill patients, may undergo undue emotional stress. An outlet should be given, such as a general discussion of such feelings in the classroom. To learn that she is exhibiting a normal reaction to the situation is of definite importance. Where does the student learn this? Are nursing students taught that each new situation which confronts them contributes to the growth of their minds by aiding them to develop a mature outlook on life?

The factor of maturity has entered into this discourse and clarification of the term is necessary. In this context, it is the ability of the individual to attain the highest possible degree of mental health; to live compatibly with himself as well as with others; to accept the responsibility for his own decisions and actions; to contribute according to his abilities to the betterment of society. These attributes are

essential to the girl who seeks to be a truly capable nurse. The attainment of maturity does not occur in the early growing years. It may be attained only by the concentrated effort of the individual.

In public health nursing, more emphasis is placed upon the prevention of disease and the education of the public than in other branches of nursing. Thus, it is in the community that the nurse must place more stress on the subject of mental health since it can be accomplished more effectively here than in the hospital. Is she well-equipped for such teaching? Psychiatric affiliation has not yet been made compulsory in all basic nursing courses in Canada but we are progressing to this point. Perhaps the future will bring not only classes in mental pathology, but also a good basic course in mental health. This will come about only through the individual efforts of all those who are concerned with nursing education. For the present we must rely solely on what her past experiences will contribute to the individual public health nurse's ability in the field of mental health.

What about inservice education in mental health for the staff of public health agencies? Here, the greatest immediate stumbling block may be found. When the subject is presented protests follow. The schedule is already crowded and it is not the agency's duty to undertake the preventive aspects of psychiatry! Another objection is that the agency does not have the staff available to provide such teaching for other personnel. The crux of this whole matter appears to be that our civilization has parcelled itself into too many specialized spheres each of which balks at the idea of trespassing into the other's field. The general hospital is basically for the care, treatment, and education of the physically ill person. The bulk of health education and the prevention of illness falls to the public health agencies. What is overlooked is that our psychiatric hospitals are equipped only for the care of the mentally disturbed individual. They are not equipped to promote the mental health of the population at large.

In order that public health workers may become aware of their responsibilities for mental health, an inservice educational program is definitely required. We must first indicate the need for such a program and then provide the qualified personnel to carry it out. To provide a starting point psychiatric social workers could discuss the aims of psychiatric rehabilitation. By using an illustration of a situation to which a former patient must return and with which he must resocialize one of the reasons for educating the public could be pinpointed. Once interest has been aroused, the program could be enlarged to include practical applications of theoretical speculation. Talks could be given at meetings of community workers where each group could decide on its own method of resolving the problem. Another method is group discussion at staff meetings in order to formulate a plan for incorporating mental health into the overall public health orientation of new staff members.

Once it has been established that the promotion of mental hygiene is the responsibility of all who are interested in the health of the community, the workers must be given the opportunity to make practical applications. One means could be through the development of a specific program such as the provision of home care for psychiatric patients after discharge from hospital. Any family that has undergone the stress of a long-term illness needs assistance. Following mental illness the stress is increased by the stigma that still surrounds it. Only by public education can this adverse badge be removed. Teaching must begin within the family. The attitudes in the home must be evaluated, the illness described and explained so that it is regarded as the same as a physical disability. The help of the family can be enlisted to aid in the general rehabilitation of the patient. Later both patient and family will need the support of the nurse as the patient returns to his job, his church and his social life. The minister, the employer, the friends of the patient must all be shown how they can help. In the course of dealing with the problems of one psychiatric patient, the public health personnel may find that they need to educate the community at large. Thus through close teamwork between psychiatric workers, public health agencies

and the public, an appreciable step forward could be made in the field of mental health.

These examples illustrate the practical application of mental health techniques in the rehabilitation of the emotionally disturbed. However, mental health is not solely the absence of mental disease. How may the other aspects of mental hygiene be promoted in the over-all program of a public health agency? A prenatal visit that includes instruction in the essentials of nutrition and exercise should also consider the emotional adaptation of the body. The mother-to-be can be encouraged to express any fears or doubts that may arise. She can be helped to adapt to the new state of parenthood. She must feel that she can turn to the public health nurse for constructive help in developing a healthy attitude toward her own future and that of her family.

The preschool and school age child is in the process of developing the basic traits and mental outlook that will have a profound influence on his adult personality. The parent who vents his feelings on the child, the teacher who punishes a student unreasonably for inattentiveness are not instilling a good concept of mental health. The public health nurse who has contact with the child, his parents, his teachers and his schoolmates needs the knowledge and techniques that can promote the growth of the child into a healthy adult. She must be able to work with both parents and teachers to help them to see and to solve the difficulties that arise either in the home or in the school. She should give them the opportunity to express their observations of the child and provide them with guidance in dealing with specific situations. In this way she promotes not only the mental health of the child but also that of the adults with whom he is in contact. The result will be the gratification of seeing healthy, happy children develop into healthy, mature adults.

It is recognized that health agencies cover a much broader field than has been indicated here. By using prenatal care, psychiatric rehabilitation and schoolwork as examples, the integration of mental health into the public health field is more easily understood. The public health nurse is not alone in her efforts to promote mental health. She is part of a team. Social workers, physicians, educationalists and other public figures are all working with her in their respective fields. The nurse, however, can integrate mental health promotion into her work of maintaining good physical health. She can help the others on the team to play their parts. Education alone will not produce the desired attitudes. There must be acceptance by the general public of the need for assistance and guidance along these lines and a willingness to practise good habits of mental as well as physical health.

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A wasted skill, a misapplied ability is a threat to the capacity of a free people to survive. A society must learn to regard every instance of misuse of talent as an injustice to the individual and an injury to itself.

— *Pursuit of Excellence: Education and the Future of America*

The Management of Crisis in Human Situations

MARY F. MCHUGH, B.N.

What is a crisis? When, why and how do crises develop? How does a nurse's ability to perceive impending crisis effect her behavior?

WHY is the concept of crisis a useful one from the point of view of the nurse? What can the nurse gain from an understanding of this concept? If one accepts the theory that all those present in a crisis situation affect responses to the crisis and the subsequent behavior, one can readily appreciate that an understanding of crisis is of vital concern to the nurse. She is part of any crisis situation in which she finds herself. The more understanding she has of how crisis develops, the better able she should be to help prevent crisis. Some crises, however, are inevitable. In such instances the understanding nurse can lend support to others involved in the situation.

Let us consider crisis as an event which disturbs the equilibrium of social relationships in a situation. My purpose is to indicate how this concept may be useful in both nursing practice and nursing education. My comments will be confined to a discussion of four factors that influence both the development of crisis in human situations and the response of the individuals.

1. The stage of life at which the event occurs.
2. The unique personalities of these individuals involved in the event.
3. The varying backgrounds of experience of individuals.
4. The values they hold.

The Stage of Life

The timing of an event may determine whether or not it is a crisis. For example, for a two-year-old the experience of going to hospital can very readily constitute a crisis in the life of that child, as John Bowlby[1] has shown. Rene Spitz[4] has indicated that the personality development of children may be severely impaired if, at critical ages, they are separated from their mothers. The film, "A Two-Year-Old Goes to Hospital," illustrates the significance of the young child's separation from his mother.

For a fourteen-year-old, a period of hospitalization would be much less likely to develop into a crisis. He can be prepared for the event. He can be helped to understand the purpose of surgery and something of the circumstances under which it takes place. Friends and relatives of such a patient take these events in their stride. They know his distress will be short-lived and that he will soon return home. The disturbance to his social equilibrium will be minimal.

Whether or not an event constitutes a crisis in the life of an individual then, is determined in part by the time of life at which the event occurs. The nurse who understands this concept may use her understanding to guide her own action and that of others in human crisis situations.

Individual Personalities

Birth, death, and serious illness are commonly accepted as crisis situations. We are less able to accept the possibility that crisis may be inherent in the transition from one phase of life to another and yet research findings substantiate this notion.

Eric Lindemann[3] and his associates in their study of community health found that the transition from a high school to a hospital school of nursing presented considerable hazards for vulnerable persons. The researchers' findings indicated that for some students the frustrations were severe enough to be considered a life crisis. The stu-

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Miss McHugh who was clinical instructor in the operating room of the Montreal General Hospital, now works in Western Canada. This paper was presented as part of a symposium on "The Management of Crisis in Human Situations" at the American College of Surgeons Convention, Nurses' Section, held in Montreal during 1959.

dents' expectations of nursing were very different from the real situation. Added to this was the grief that resulted from leaving family and home. These factors, along with the anxieties stimulated by the relative intimacy of living together in a residential program and the confusion resulting from comparisons between the ideal role of the nurse and the actual nurse behavior encountered, temporarily destroyed their equilibrium.

If we ourselves have not experienced some of these reactions in the transition from a high school to a professional school, most likely we have observed them in others. Some student nurses can take this transition in their stride. Others experience varying degrees of difficulty and for some the crisis is one that they can resolve only by leaving. This concept has implications not only for nursing educators but for all members of the helping professions. Whether or not an event constitutes a crisis in the life of an individual is determined, in part, by his unique personality.

Background and Experience

What has gone before in a person's life influences his perception of a present situation and the way in which he responds to it. Two people with similar illnesses who are faced with the prospect of hospitalization and surgical treatment may respond quite differently. Their different responses are due, in a large measure, to earlier experiences. All of us are familiar with the patient who feels at home when he comes to the hospital, who knows what is expected of him and who feels that he will be looked after. He feels secure in the presence of those to whom his care is entrusted because his previous experiences with hospitals have been satisfactory.

We might contrast this patient's response to hospital admission with that of the patient who comes to the hospital for the first time. He does *not* know what is expected of him nor what to expect of the many strangers around him. Unsure of what will happen to him, he may be most anxious and apprehensive. Admission to hospital has a particular meaning for this patient. Unless appropriate measures are taken to relieve his anxiety, it may well increase. When those who are caring for the patient appreciate the meaning of his emotional response, they are better able to alleviate his excessive anxiety and to prevent it from influencing the course of his illness or interfering with the effectiveness of his treatment.

A crisis may develop for those persons whose past experience makes a specific situation especially meaningful emotionally. Health workers who understand this concept should be prepared to anticipate the development of a crisis situation and, through their understanding, function in the way most likely to relieve tensions and prevent crisis.

Individual Values

Whether or not an event becomes a crisis situation for an individual is influenced by the values the individual holds. These have a specific function. They are the bonds that hold the personality together and give it direction. On the social and cultural level widely shared values perform the same function for the group. The fundamental things in which people believe determine in a large measure the way that they see situations and the manner in which they respond. Individuals, families, other institutions, professions and communities all have their unique value systems. It is possible that few conflicts would arise if values were coordinated and consistent. However, this is not life. At all levels, values tend to be imperfectly coordinated and their inconsistencies contribute to the development of tensions within and between people. If these tensions become sufficiently severe, crises will arise.

Inconsistencies in values can be demonstrated in any profession but perhaps such inconsistencies are most evident in a developing profession such as nursing. As hospitals increased in size and complexity specialization occurred. Enrolment in schools of nursing increased and the trend to separate nursing education from nursing administration developed. In some instances, nursing leaders in hospitals tended to form two groups whose interests and skills were developed primarily in the area of either nursing education or nursing administration.

Although the ultimate goal of both groups was the same — patient care — the way in which one group perceived the situation tended to deny the value of the other group's viewpoint. The teacher saw the ward as a place where the educational needs of the students might be met. The head nurse saw it as a situation demanding a given amount and quality of nursing service. Neither one would deny the importance of the other's interests but in this instance the head nurse's values would be largely at one end of a *continuum* and the teacher's values at the other. Such situations create tensions which can be relieved only when values are coordinated.

Most nurses will agree that we have only begun to recognize this problem in nursing and to take steps towards its solution. Through understanding and working together we may be able to prevent the crisis situations which arise out of uncoordinated values within the profession. We could then direct the energy we now use in such situations toward the development of our profession.

Summary

We have considered crisis in human situations. We have implied that an event, of itself, does not constitute a crisis. Rather the degree to which the event disturbs the equilibrium of social relationships determines whether or not a crisis develops. We believe that the ability to perceive impending crisis can be developed and that most crises can be prevented or at least minimized by those who, because they are aware of the factors involved, can respond effectively.

The assistance of Mrs. Helen Gemeroy, assistant professor of psychiatric nursing, McGill University, Montreal is gratefully acknowledged.

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As nurses, we do not diagnose or recommend medications, but there is nothing to prevent us, legally, from recommending a good book. Nor would we be doing any patient a disservice by knowing something about books and current reading materials. Some patients need only to be led to the realm of books to be introduced to a whole new world. Some need to be reminded that books exist, and some — far too many — will need to be guided to a proper choice of reading.

Nursing Outlook, November, 1959

* * *

Injustice is relatively easy to bear; what stings is justice. — H. L. MENCKEN

* * *

All of us are becoming more price conscious, more aware of the shrinking value of the shopping dollar. The monthly cost of living index reported by the Dominion Bureau of Statistics used to show the monthly figure with the values in 1939 as the basis for comparison. After the figure so obtained had sky-rocketed, the comparative figures were based on the level in 1949.

With some nostalgic yearnings for the "good old days" of 1939, here are some comparisons of interest to every wage-earner. The 1959 figures are based on prices in Montreal in December, 1959.

Item	*1939*	*1959*
Milk (quart)	$ .10	$ .23
Bread (24 oz. loaf)	.10	.22
Butter (lb.)	.31	.65
Coffee (lb.)	.25	.99
Calves' liver (lb.)	.48	1.45
Round Steak (lb.)	.30	.98
Bus ride	.08	.20
Cigarettes (20)	.25	.40
Medium-size car	1,000.00	2,800.00
Small house	4,500.00	10,000.00
Subscription to *The Canadian Nurse*		
Through fees		2.00
Personal	2.00	3.00



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Hospital Insurance and the CNA

In November, 1959, the CNA presented a submission to the Advisory Committee on Hospital Insurance for the organization and financing of hospital schools of nursing.

The CNA, recognizing the large sums of money which are presently being spent for schools of nursing and expressing grateful appreciation of this, advocated that:

> The monies available and to be assigned to nursing educational programs in hospital schools of nursing be
>
> 1. reserved and used to enhance the educational calibre of the program
> 2. administered by those directly responsible for the educational program of the school.

The CNA advocated that the school be regarded as an autonomous educational institution, in this instance, having the right and responsibility to control the student's entire experience — academic and clinical — in the interests of that student's professional preparation as a nurse.

CNA Sub-committee on Finance

A meeting of the Sub-committee on Finance was held at National Office on December 19, 1959. It was recommended that a Sub-committee on Investments be formed. The terms of reference of CNA loans were reviewed. The two criteria for granting of loans still stand —

1. that the applicant be a member of the CNA
2. that the money would be used for advanced preparation.

Mental Health Institute

The Dalhousie University School of Nursing held a three-day institute on Nursing Aspects in the Mental Health Program February 24 - 26, 1960 in the auditorium, Victoria General Hospital.

Miss Peggy Pike, head of the Psychiatric Nursing Research Department of Allan Memorial Institute, Montreal, was the conference leader, ably assisted by Dr. Robert O. Jones, professor of Psychiatry, Dalhousie University, and other specialists in this field.

The CNA Retirement Plan

The Canadian Nurses' Association Retirement Plan is actually two plans in one — "A" and "B". Plan "A" is designed for nurses who are self-employed or are employed where no employer contributions are available and who must therefore rely on their own savings to provide for retirement. Plan "B" is designed for nurses who are working for an employer who will join with them in setting aside money for their retirement.

Within each plan there are two funds in which the nurse may place her contributions — the Insured Annuity Fund and the Common Stock Fund.

In the Insured Annuity Fund, the pension you buy is determined precisely at the time you join the plan according to your age and the amount that you save. This may be increased by the dividends credited to you by the insurance company during the time that you are saving for retirement.

Under the Common Stock Fund, your contributions are invested in a well-balanced portfolio of common stocks of leading corporations. Your share in the Fund is sold when you retire and the proceeds are applied to purchase a pension at that time. The amount of pension that is then bought will depend on the market value of common stocks at that time.

All members of the Canadian Nurses' Association who have not attained the age of 70 may join Plan "A", the personal plan, or Plan "B", the employer-employee plan, (within the terms set by the employer) of the Canadian Nurses' Association Retirement Plan.

A Review of the Pilot Project

HELEN MUSSALLEM, M.A.

Getting ready for such a far-reaching development as the evaluation and accreditation of schools of nursing requires comprehensive preliminary studies.

THE Pilot Project for Evaluation of Schools of Nursing has been completed. The report of this study which will be available to all members of the Canadian Nurses' Association is in the process of being published. The recommendations made as a result of this study have been reviewed by the Executive Committee of the Canadian Nurses' Association. During the project, information on each step appeared in "Nursing Across the Nation." A brief sketch of the total project will bring everyone up to date.

For many years, the Canadian Nurses' Association had considered the feasibility of initiating a program of accreditation for schools of nursing in Canada. At the general meeting in 1956, the Association approved a resolution to study all aspects of such a program. This decision was motivated by the belief that if the quality of nursing service rendered by the profession was to be improved, then preparation for that service must be improved. It was also recognized that nursing, as any other profession, had a responsibility for evaluating its own program of education.

Purposes of the Project

Following the general meeting, the purposes of and a plan of action for a Pilot Project for Evaluation of Schools of Nursing were formulated by a special committee. These purposes were:

1. To determine whether Canadian schools of nursing are ready for a program of accreditation and, if it is feasible at this time, to initiate a program of accreditation.
2. To determine the basis on which schools of nursing in Canada can be accredited.
3. To explore procedures for carrying out an accreditation program.
4. To determine the personnel and other resources needed to carry out a national program of accreditation.
5. To estimate the cost of a national program of accreditation.
6. To acquaint the Canadian people with the needs of nursing.

Selection of Schools and Visitors

In order to obtain the necessary data, each of the 174 diploma schools was invited to indicate willingness to participate. Ninety-six schools volunteered. From this group the special committee for the Pilot Project selected 25 on the bases of geographical location, size, control and type of program. At least one school in each province was chosen. Two schools were selected in each of the four Western Provinces, five in Ontario, seven in Quebec (five of these were French language schools), and five in the Atlantic provinces. The committee also named ten regional visitors to participate in the surveys of the schools, and one senior bilingual evaluator.

Orientation of the Director

A director for the study was ap-

Miss Mussallem took leave of absence from her post as associate director of the school of nursing at Vancouver General Hospital in 1957 to become director of the Pilot Project.

pointed in September, 1957. In preparation for her responsibilities in directing the Pilot Project the director worked with the National League for Nursing Accrediting Service for four months, studying the philosophy and procedure of their program with a view to adapting these methods in the survey of selected schools of nursing in Canada. This orientation included participation in accreditation visits in widely distributed geographical areas in the United States. It was a most interesting and stimulating experience. One could not but be impressed by the dynamic nature of their program.

The policies, criteria and procedures followed in the American accreditation program in nursing are based on principles widely accepted and tested in education for the other professions, and in general education. Accreditation in nursing is more than an evaluation. It is a program in which the educational units themselves play a vital part. It aims to help schools in their efforts to improve the nursing program they offer by providing them with assistance in the continuous process of self-evaluation. The impression gained was that voluntary national accreditation could be a most effective means of encouraging schools of nursing to improve their programs.

Preliminary Visits

In initiating the Pilot Project, it was decided that prior to the full week survey, a preliminary visit should be made to each participating school. Accordingly, a one-day visit was made by the director to each of the selected schools in order to acquaint the faculty and administration with the survey procedures and to explain the types of suppplementary data required.

Interpretation of the Project

Activities carried on during the preliminary visits and surveys of schools of nursing included conferences with provincial deputy ministers of health, and with national executive directors of organizations. Interviews were also arranged with the national Deputy Minister of Health and other national representatives interested in the Project. Addresses were given, on request, to such groups as provincial registered nurses' association meetings, hospital association meetings. Workshops were conducted on the evaluation of schools of nursing.

Press releases were sent from National Office during the preliminary visits, and the majority of the local papers printed the information. Because of a decision of the CNA Executive not to publicize the names of the schools being visited, newspaper publicity for the full survey visit was left to the school concerned. In areas where the schools released this information, it was encouraging to note the coverage given. Several press interviews were held, as well as interviews on radio and television.

Following a recommendation from the National Committee on Nursing Education, a communication was sent to the provincial executive secretaries, indicating that the regional visitors were prepared to interpret the project in their area, and many requests for this were filled. Other means used to keep people informed included: memos sent out from time to time to schools participating in the Project, magazine articles, report to the Joint Committee on Nursing, etc.

The Survey of the Schools

A one-week survey visit was made to each selected school of nursing during the latter part of 1958 and up to April, 1959. The purpose of the visit was to validate and clarify the written material describing the program, as well as to assist the faculty of the school in identifying their own problem areas and to develop skills in seeking solutions to these problems.

The survey team consisted of the director of the project and one regional visitor from a neighboring province. The regional visitors were all nurses well qualified for this role both by experience and personality. In the visits to the French-language schools, Sister Denise Lefebvre, who has given great leadership throughout the entire Project, acted as the senior bilingual evaluator. The survey teams were fact-finders; they did not evaluate the program.

The Visits

Each visit was a stimulating and exciting experience. The visitors were impressed by the very favorable re-

action of the directors of the schools and in fact the entire staff of each hospital. No effort was spared to make all required information available. Their keen interest in the evaluation process, and their warm hospitality went far beyond what was anticipated.

The visit to each school was planned to take six days. Monday was used to study all the written materials describing the program. These materials included the questionnaire which was 69 pages in length and took most schools three to four months to complete, and 21 additional items such as: the Minutes of all meetings, copies of all rotation plans in use, a copy of the articles of incorporation or other evidence guaranteeing the legal right of the hospital to operate a school, copies of all contracts with cooperating agencies, a complete set of all course outlines, etc. The next three days constituted the actual visit. Each evening and all day Friday the visitors were busy writing the report. Saturday morning the report was read to the members of the staff. Saturday afternoon any necessary corrections to the report were made. Sunday the visitors travelled to the next school. Each survey required approximately 65 working hours.

Writing the Survey Report

When the data had been verified, the visitors wrote a report on the program. With two visitors on the fact-finding survey team, a more exact and unbiased report could be written. The report described the program; it did not evaluate it. Each survey report was typed at National Office and sent to the director of the school for further correction. When it was returned to National Office, the report was stencilled and sent to members of the Board of Review for evaluation. This rather lengthy procedure ensured that the school's reports used as the basis of the data analyzed in the Report of the Pilot Project was accurate.

The Board of Review

The prescribed procedure provided for a board composed of ten members who would study each survey report and pass judgment on the educational program of the school surveyed. Eight board members were nurses representing all the types of programs being evaluated. There was also one representative from the Canadian Medical Association and one from the Canadian Hospital Association. The board met twice; once in October, 1958 for orientation and the review of five survey reports with a final meeting in May, 1959 for evaluation of the remaining schools. The decisions made by this group on the status of the schools are included in the final report.

Evaluation by the Participants

To assist in the evaluation of the techniques used in the Project, the schools were asked to evaluate this entire process. The guide questions were:

1. What have you liked in this evaluation procedure? (strengths)
2. What areas in the procedure might be improved? (weaknesses)
3. What suggestion for change in procedure would you recommend?
4. After having participated in this survey of the Pilot Project, do you believe the Accreditation of Schools of Nursing in Canada would be desirable? Why?
5. Other comments.

The responses were not most encouraging. Some of them appear in an Appendix of the final report. A fairly typical response of the reaction to the total project is summarized from comments made by one of the directors of nursing whose school was visited:

> The Evaluation Program is a means of helping schools raise their standards. It is neither a loss of time nor a waste of money. On the contrary, it helps schools of nursing to keep pace with modern progress.
>
> Having participated in the Pilot Project, our vision has been considerably lengthened. We are more acutely aware of our shortcomings than ever before. People do a better job when they know what they are supposed to do, when they understand what authority they have, when they realize what constitutes a job well done in terms of scientific results, and when they are aware that what they are doing is of value.
>
> The visit made to our school by the survey team has given the teaching body, the administrative personnel — in fact our entire staff a more adequate sense of direction.

The Decision on the Project

The report on the Project has been completed and recommendations have been made. This report will be distributed by each provincial nurses' association to the members for study prior to the biennial convention. It is at this meeting that the membership will decide, in the light of this study, on the best course to be followed in order to maintain better nursing service through better nursing education.

The Psychiatric Nurse as an Observer

ELISABETH RATKOWITSCH

The psychiatric nurse's ability in the role of observer can make a significant contribution to the patient's recovery. Is the need for keen observation confined to psychiatric nursing? How can nurses become therapeutic observers?

EVERYONE observes people. The primary motives are either idle curiosity or a basic desire to understand others. Most psychiatric nurses possess a cultivated curiosity and an eagerness to understand. Observing patients is one of their chief roles and it should be done with a sincere interest in and desire to serve the patient. A certain degree of curiosity is doubtless essential. To be merely curious about a patient is certainly not desirable. It must not be forgotten that mentally ill patients are human beings and not inanimate objects.

More and more a psychiatric nurse is expected to be a keen observer and to record and report her observations. Each contact with the patient is an opportunity to observe: to find out how he can be helped, what he is saying with his behavior, what he needs, what kinds of experiences he requires. With this approach it is possible to note and to communicate observations and to use them in determining how to help the patient to foster his own emotional growth.

As a participant observer the nurse scrutinizes not only the patient's behavior, but also her own. She studies responses and learns how to use her relationship constructively. It is very important for her to become aware of her own feelings toward the patient and of how the patient views her. Naturally, there are limitations in her ability to recognize what is going on. Therefore, a collaborative relationship with the psychiatrists, psychologists and other members of the health team is essential. Harry Stuck Sullivan states:

> Whatever the techniques employed for observation of human behavior, including verbal report of subjective appearance, it is important to note that the act of observation is itself human behavior and involves the observer's experience . . . When it comes to the matter of perceiving another person, not only is there the object and the perception of the emanations from the other person, but also the distorting, confusing and complicating factor of our past experience with other people who looked like this, who sounded like this, etc. In other words, it is fabulously more complicated than is the case with non-personal reality.

To make keen and objective observations is a complex task. Some nurses have a natural ability, others gain it by training and experience, some will never possess it. Objectivity means truth in what we observe and in personal insight. To be objective is not a simple matter. Most members of a nursing staff will admit that their

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A graduate nurse from Graz, Austria, Miss Ratkowitsch was on the staff of Victoria General Hospital, Winnipeg, before going to the Allan Memorial Institute, Montreal, for postgraduate study in psychiatric nursing.

observations are not always objective. They get twisted either by personal feelings or by misinterpretation. Few nurses deny never being subjective.

Factors in Ability to Observe

1. The personality of the nurse
2. Her past experience, skills, educational background
3. Her age
4. Her interest in the patient
5. Her physical well-being
6. Her relationship with the patient's doctor
7. Her flexibility.

It can be easily understood that the personality of the nurse affects her observations. How many times does a hostile nurse report or chart that patients are hostile? She projects her own hostile feelings. To perceive hostility in someone else is to avoid perceiving it in oneself. There is the depressed, downcast nurse. She seems to see things more darkly than they exist; the patient's condition appears to her to be poor or hopeless. There is the fearful nurse. She is blocked from seeing the patient's anxiety and insecurity. The more preoccupied she becomes with her own fear, the less able she is to see how frightened the sick person is and to find ways of relieving his fear. A selfish nurse, who cannot bear it when a patient prefers another staff member, will seldom have a positive statement about this patient. If only all nurses could understand that many unpleasant experiences such as rejection, attack, suspicion and disrespect cannot be taken personally. Nurses have to keep their balance, accepting objectively the opposite experiences of admiration, praise, dependence, etc.

It also seems to be very difficult to be objective when the nurse is too emotionally involved. There can be no personal relationship without emotional involvement, but it should not be overdone. When it is, there is a tendency to see the patient's behavior as more acceptable and better than it really is. The actual situation will be overlooked and the patient will be protected whenever possible. The less training and experience the nurse has, the easier it seems to be to become involved. The older, experienced nurse is more alert. It is not unusual to hear a young student nurse say about a very sick, but good-looking man: "Oh! he is most charming, so marvelous and interesting. I can't see anything wrong." She probably will not report that the patient was slightly intoxicated when downtown. Instead she charts that he went to a movie, then to bed on his return.

Psychiatric patients as well as all other sick persons often become too dependent on the staff. They like to be babied and are requesting a relationship so close and so filled with love that a nurse never can satisfy them. When they become active and are well again they are equally anxious to drop this relationship. A few nurses find this hard to understand since a dependent or "sticky" patient fulfils some of their own neurotic needs.

The ideal psychiatric nurse is a happy, sensitive person who has outside interests and who feels that she can accomplish much in her work. She becomes less emotionally involved and sees things more accurately. There seems to be a relationship between the ability to observe and the level of insight that a nurse may have.

Accepting an awareness of our conscious behavior is a difficult problem. It can hurt to recognize and to admit personal problems. Everyone has them — psychiatric nurses are no exception. Being a New Canadian and having spoken English for only two years, I hesitated at first to chart that a foreign patient's command of English was poor and difficult to understand. I identified myself with him and felt that if I put this down I would be confessing my own lack of knowledge of English. I had to force myself to write the facts.

Observations can be influenced by the relationship between the nurse and the patient's doctor. For example, examine the following nurses' comments:

> We don't bother sometimes to report to a hostile doctor.
>
> If we get support from the individual doctor, we are more interested in making accurate observations.
>
> If I dislike a doctor, I make less careful observations.
>
> If the intern works alone, I am less on my toes.

Sometimes there appears to be a lack of collaboration between the nurses

and the newly arrived intern. Many of these inexperienced young psychiatrists show resentment at being dependent upon nurses' observations. They very seldom ask a nurse about a patient and do not like to be told how a patient is behaving. They depend almost entirely on their own observations — studying the patient for a short time each day. As the intern becomes more experienced he becomes more tolerant of the nurses and begins to realize how much their observations can contribute.

Staff doctors as a rule are more interested in nurses' observations. A few of them read them and combine the intern's notes with the nurses' reports in the weekly progress notes. Most doctors consider that the nurses' observations are very important and valuable. They realize that she is the one who observes the patient over a 24-hour period, who sees him when he is far from being at his best. She is with him during all moods, through all phases, at mealtime, at ward activities and with his visitors. She observes his appearance, attitude, mood, appetite, activity, reaction to routine and his sleeping habits.

Nurses have expressed the idea that psychiatrists fear that they may interfere with psychotherapy or attempt to interview and interpret. The doctors I questioned did not see any danger of interference with psychotherapy. The opinions expressed about interpretation were all much the same. It was generally felt that nurses' interpretations are unreliable because different nurses will interpret in different ways. It must also be remembered that the doctors receive reports from nurses at different levels of experience: student nurses, postgraduate students and graduates. Doctors prefer a description that is expressed in good but simple English without interpretation and without psychiatric terminology.

Medical researchers are an exception. They expect observations on a different level. For example, the nurse observes that a patient spends hours and hours in front of the mirror. To the researcher she can report that the patient is *narcissistic*. In another instance, the nurse notes that a little man eats enormously. He asks for two bowls of porridge at breakfast, six pieces of toast, drinks four cups of coffee, is very talkative throughout the day and likes smoking. The researcher is the only one who will be pleased to hear that this patient's *oral needs are increased*. Other psychiatrists prefer to get the full description. The nurse must describe in detail what she sees and hears and not what she *thinks* the patient is doing or how she *thinks* he is behaving.

There are varying opinions as to whether or not it is training and experience that make intelligent observers. Some doctors and nurses think that this ability definitely depends on training; that the important symptoms have to be pointed out first so that they can be recognized and noted. Others feel that training is not as important. They recalled untrained personnel who had made very good observations and had been more sensitive to patients' needs than some nurses with training in psychiatry. Certain nurses can receive a good training, become theoretically excellent, but be of little use to patients because they lack understanding and warmth.

It is a difficult task and takes time and effort to become a good psychiatric nurse. Formerly, in the general hospitals where nurses trained or worked, nursing care was categorized and not too much emphasis was placed on treating the patient as a total individual. The sick person was treated according to his diagnosis which was related to an illness or bodily function. Too often his emotional needs were overlooked. It was not recognized that the illness and all that it implies were most important to him and that he reflected this in his moods. Many patients become very anxious and self-centered.

In psychiatry, a diagnosis is mainly important for its use in research and statistics. The mentally ill person is treated according to his individual needs. Differences in his needs are related to his personality as a whole. The nurse brings many skills to this new field, but she has to relearn them and develop new powers. Her personality, mind and ability to be a good observer of human behavior are more important now. The hands and feet suddenly have not much to do. With them alone, little can be accomplished.

A patient spent hours drawing a picture of his favorite nurse. He gave much attention to little details, but he gave the nurse no hands. The art instructor reminded him that they were missing and that the nurse certainly needed them. But he answered in a firm voice: "They are absolutely unimportant. She is not using them. All she does is talk with us."

He was quite right. The nurse never brought him medications, never touched him, but spent her time talking to him. She was trying to foster his trust and confidence in people and to make his life worthwhile again.

Most new nurses in a psychiatric unit are surprised to find themselves among patients who are ambulatory and who are people not unlike themselves. Outwardly they differ only in the display of their emotions and the way in which they solve their problems. Many of them are very intelligent. At first, is it often difficult to know what to look for and what is significant. Many small things are not taken for granted in psychiatry. It is important when a patient who has never initiated conversation suddenly starts to talk with somebody or when an untidy patient starts to take pride in his personal appearance and shaves for the first time. The gross behavior changes can be observed without much effort. A child can recognize anger when dishes are thrown around, but to recognize minute changes in behavior calls for alert personnel.

It is uncomfortable at first to sit down and talk or play with the patients. Many nurses are afraid of saying the wrong thing. They do not know what to expect from the mentally sick. It is hard to understand that psychiatric nurses do not play cards or checkers for their own amusement or to pass the time, but that this has therapeutic value for the patient and gives the nurse a good opportunity to observe him. Most patients feel uncomfortable if a nurse sits quietly watching them. She must first learn to gain their confidence, show interest and be considerate. The nurse should avoid interviewing patients too quickly. A patient was once asked too many questions in a relatively short time in an attempt by a nurse to find out how he spent his day. She had spent very little time with him and had no information for report. This sensitive man remarked:

Nurse, you are not really interested in my welfare. You have only a professional curiosity and have come to check, so that you know what to write down on the nurses' notes.

The more experienced the nurse becomes, the less time she requires to make valuable observations. Some nurses know more by being with a patient five minutes than others would in a few hours. It is similar to people who are familiar with a city. They will find their way around in less time.

Nurses often find it difficult to observe a quiet patient. The majority seem to know more about someone who is outgoing or an exhibitionist. Reports on him are usually of better quality and quantity. The quiet person has the fewest and least informative nurses' notes. His name is more likely to be left out in staff discussions. Most nurses know very little about him. They record the same things every day — that he is not mixing or socializing, occupies time poorly, etc. The nurse has to realize that this patient is withdrawn and isolated and not an introvert or a bore. He needs help and understanding. As soon as she becomes curious and interested, the patient suddenly becomes more alive to her. She notices more details about him.

By careful observation of the withdrawn patient the nurse will be surprised at how many things can be observed. These observations are never a waste of time or boring. A patient tells many things through his silence, but a nurse has to learn to understand non-verbal communications. She can observe his body movements, his facial expression, his eyes, his posture and positions. She also must be astute to subtle hints that such a patient is ready for contact. A relatively minor action can mean a big step to the patient. He expects the nurse to note it. Another positive example of keen observation and intervention occurs when a nurse recognizes that a patient is contemplating suicide. The risk should never be minimized and mounting tensions must be noted.

Summary

Being an observer is one of the

major roles of the psychiatric nurse. She can observe most effectively as a participant. She must observe herself, know her own abilities and difficulties, be introspective. Good observations should be objective, but there are many factors influencing them. For most nurses, it is impossible to be completely objective because of personal feelings and various temperaments. Nurses need support and help from the other team members in order to function most effectively. They must learn to control themselves and should never stop growing emotionally.

A good nurse is sensitive to what her patient needs and what he feels. All of her observations are an intermediate link between patient and doctor and have a therapeutic function.

Reactions to Visitors in a Psychiatric Unit

Barbara H. Nelson

Modern psychiatry recognizes that relatives are important members of the team which endeavors to assist a patient to return to health. The questions that then arise are: who visits, when, how often and for how long?

The Purpose

The purpose of the study was to consider the question of visiting in a psychiatric unit with respect to:

1. The effect visitors have on patients,
2. the doctors' and nurses' attitudes toward visitors,
3. the effect visiting hours have on the activities which have been organized for the patients.

Not too many years ago, mental illness was considered to be a social disgrace. Accordingly, the person was put away in a mental institution and promptly forgotten. At this time, an ideal relative could be described by hospital authorities as a person who appeared with the patient on admission, gave a complete and accurate history, and then disappeared, except for paying the bill . . . by mail. Relatives were often blamed, consciously or unconsciously, for the illness of the patient, by staff and patient alike.

Through recent advances in psychiatric medicine, it has been recognized that relatives do play an important role in the return of the patient to a normal way of living.

The Setting

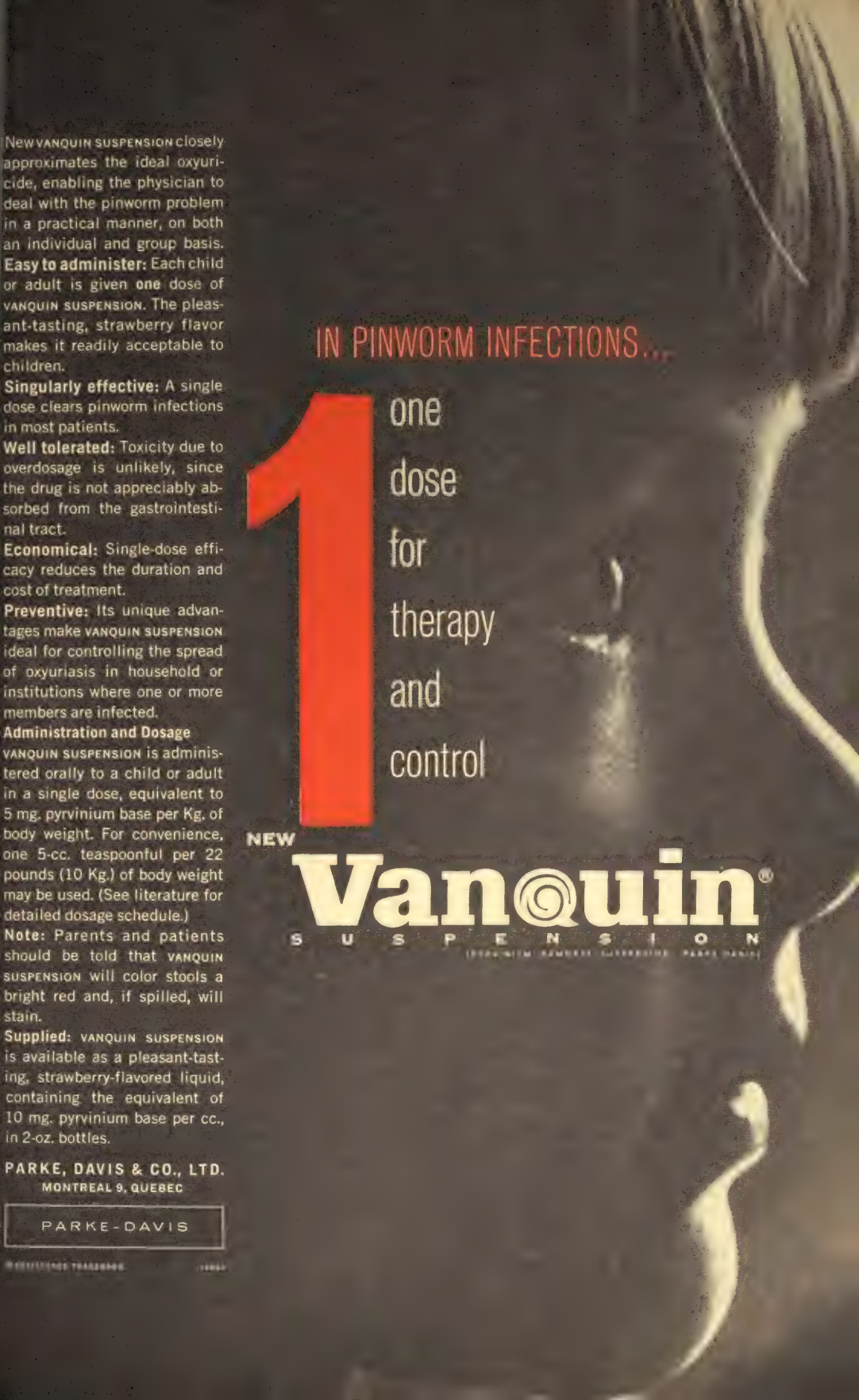
This study was undertaken at the Allan Memorial Institute, an open 125-bed psychiatric unit. The institute, is part of the Royal Victoria Hospital of Montreal.

In considering the question of visiting in this psychiatric unit we are dealing with the organization and function of a unit which has as its objectives: the care of the mentally ill person, the advancement of psychiatry through research, and the teaching of personnel involved in psychiatric care. We are also caring for someone who comes from a family and a place in the community. It is the individual patient who will make for many variables in this study. The type of illness the patient has, plus his personal life, will affect the answers that are obtained.

The visiting hours at the Allan Memorial Institute have recently been approved as follows: there are visiting periods three afternoons and seven evenings a week.

At the time of the extension, the assistant administrator of the hospital was interviewed in regard to the reasons for the change. The following reasons were given:

Miss Nelson, a graduate from Saint John General Hospital, undertook this study while she was a postgraduate student in the Psychiatric Nursing Course at the Allan Memorial Institute, Montreal.



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1. The number of people visiting at any one time would be decreased if the hours were increased.

2. The patients in the rest of the hospital may have visitors every day.

3. Visitors would not have to remember what nights they could visit; thus embarrassment of the receptionist, nurses and visitors might be avoided if the visitors arrived on a non-visiting day.

4. There would be no resentment on the part of patient and visitor if some visitors were allowed and others were not.

5. Some visitors were entering by the side door on non-visiting days, so it was thought that better control over visitors could be established.

6. Visiting every day would establish better public relations.

Methodology

Data was gathered by observing patients before, during and after visiting hours and interviewing patients and staff. The latter included staff doctors, residents, graduate nurses of all levels and the group social worker. All were chosen at random.

The patients who were interviewed and observed will be divided into four groups of five each, according to diagnosis: depression, schizophrenia, anxiety and senility. Questions asked the patients were:

1. Who were your visitors — relatives and/or friends?

2. How frequently did they come and how long did they stay?

3. How did you spend your time with your visitors?

4. What were your reactions to your own visitors and to those of other patients?

Findings

Depressed patients:

This group of patients had few visitors because they did not wish to be bothered with people except members of their immediate families. Several patients had only their husbands or wives visit because they felt it was a social disgrace to be in a mental institution; their friends did not know that they were in hospital. The visitors came on an average of three or four times a week and stayed the full length of time allotted or longer. The time was spent mainly in their own rooms, often in complete silence for long intervals.

> One patient went with her husband to some of the dances and sometimes played cards on the ward, because her husband thought it was best for his wife. The husband found it easier to put in the time by becoming involved in some activity. If they were not involved in activities his wife, who had ambivalent feelings toward him, would remain silent or would leave him alone in her room while she talked with other patients. On the other hand, this patient expected her husband to come each evening *because the hospital had visiting hours.*

The depressed patients displayed varied reactions to their visitors. Some were very demanding and very dependent on their marriage partner and their children. Several displayed anxiety and fear when they were expecting visitors and frequently feelings of guilt were deepened. Some patients became more depressed when their company arrived, bringing many home problems with them.

> A 62-year old female patient from a distant city became depressed while her relatives were with her. She stated that she knew they would be going home and she was unable to go with them. She felt that the length of visits should be shortened because she found she became very exhausted and restless at the thought of being left behind. This patient had to readjust to hospital routine each time her family returned home.

Generally speaking, other patients' visitors had very little effect on these patients. One did have a feeling of rejection because she had none. Several, whose relatives lived out of town enjoyed other patients' visitors. The patients stated that the visitors were useful in helping them to occupy their time, in doing errands for them and in keeping them in contact with the outside world.

Schizophrenic patients:

Their reactions to visitors were not unlike those of the depressed patients. They saw mainly their parents. The visits were frequent and usually lasted for the complete visiting time. One group of patients enjoyed having their parents come because this kept them in touch with reality. They were motivated to pay attention to grooming and to participate in games, such as scrabble. These patients became very

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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dependent on their parents.

The other group of schizophrenic patients had ambivalent feelings toward their parents. They would wait for them and would become very depressed if they didn't arrive. If they did come the patient would become very upset and display hostility toward them.

One patient would cry if her mother didn't arrive and on other occasions would scream at her mother and then walk out leaving her alone in the room. One young girl would sit with her mother in the day room and completely ignore her. Another patient became extremely depressed after she saw her relatives for the first time following sleep treatment. She realized that she seemed strange and different to her young cousins with whom she lived. She also realized that she had to make an effort to be sociable in order to be accepted. This incident helped her a great deal toward making the necessary adjustment to reality.

Visitors of other patients appeared to have very little effect on the schizophrenic patients.

Anxious patients:

In contrast, these patients and their visitors presented a different picture. In general they had numerous visitors, including family and friends, who came regularly and usually stayed the full visiting time. The visitors who lived in Montreal joined in ward activities because they came often and got to know many of the patients.

One patient who was from out of town, wished to be alone with his wife. He felt that the length of the visiting hours could be extended because of the difficulty his wife had had in coming to the city. Although he did not include his wife in hospital activities he felt that visitors helped to stimulate the evening program and make it a success. He thought that it was good for the patients to associate with visitors. He had many guilt feelings after his wife left because it brought to focus his failure to support her.

A female patient from Ottawa whose sister came on week-ends, became very dependent. She felt that her sister brought her into contact with the world again. She experienced a great deal of anxiety during her sister's visits. She stated that she was afraid she had not improved enough and that her sister would be disappointed. This patient had very few friends come because she had not let them know where she was. The one friend who came had been a patient in a psychiatric hospital. This friend was enjoyed very much because she offered support.

A 64-year old woman with a diagnosis of anxiety hysteria received numerous relatives and friends frequently and for the full length of time allowed. She enjoyed her visitors greatly. In them she had sympathetic listeners to her various somatic complaints. She did introduce them to patients and staff and joined with them in some hospital activities. Sometimes, when they remained for the full visiting period, she found her visitors exhausting.

Senile patients:

In this group different observations were made. The visitors did not come as frequently as those of some of the younger patients as they were elderly and not able to come every day. Several of the patients had great memory deficit so did not realize who came, how long they remained or how often they came. They were relaxed and contented while their family was present but became very confused after their departure and made many attempts to leave the hospital. Among the patients who had good memories, old friends as well as relatives came. These patients really enjoyed their visitors. It was a treat and a delight for them to sit down with old friends and reminisce about the olden days. They usually kept their visitors to themselves. They were seldom affected by other patients' visitors.

Conclusions

In comparing these four groups of patients, it would appear that depressed and schizophrenic patients had fewer visitors, mostly members of their families. The anxiety and senile patients received friends as well as members of their families.

The frequency of visits and the length of individual visits with each patient varied with factors such as where the visitors lived and whether they became involved in ward and hospital activities, such as dances and movies. The evening visiting time, 7:00 P.M. - 8:00 P.M. overlaps with the movie time, which is 6:30 P.M. and



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the dance time which usually starts between 7:30 and 8:00 P.M.

The depressed patients became extremely dependent on their relatives. Some became more depressed and had to readjust each time their visitors left. Many times the presence of visitors produced more guilt feelings in the patients. Some depressed patients became more depressed when other patients had visitors and they did not. This caused a feeling of rejection.

In the acute stages, the schizophrenic patients would be better if they received no visitors, particularly their parents. The main objective in treatment is to remove them temporarily from their environment because they are unable to accept it. After treatment and before discharge, it would seem to be valuable for these patients to receive visitors. They would help the patient to establish contact with his former environment while the patient was still getting protection from the hospital; this would be a temporary situation between complete isolation from the outer world and living in the community.

The anxious and the senile patients benefited from visitors. They enjoyed mixing with all the visitors and generally had a social evening with them. On the whole, visitors helped these patients maintain contact with the world even though at times anxiety was produced. The senile patients received fewer visitors than others, but they definitely enjoyed them.

Opinions of the Staff

The doctors were asked the following questions:

1. How frequent and how long should visiting hours be in a psychiatric hospital?
2. What effects do visitors have on the patient?

There were different opinions on the above questions, but one answer all doctors gave was that visiting should be determined on an individual basis.

Some doctors stated that in the acute phases of illness, visitors should not be allowed. Others expressed the opinion that patients should not have visitors for the first week or two. Mental illness develops when the person is unable to handle conflicts between self and outer stimuli. In order to treat these people they are removed from the home environment. An attempt is made to establish a new pattern of life and to learn how to deal with interpersonal relations in a controlled situation. If the patient is able to have his environment brought to him in the form of visitors from the time he is first admitted, the purpose of hospitalization is defeated. There are times when there are exceptions that would prove worthwhile, for example, in the case of a language barrier. One doctor stated that if the patient's environment was brought to him in the form of visitors, he might as well be treated as a day patient or on an outpatient basis.

Several doctors felt that there should be no set rule for visiting. The patients should be able to receive visitors whenever it is convenient for the staff. It was stated by some that it wasn't the frequency of visitors, but the type that counted. If a patient has guilt feelings toward a parent, the presence of this person would only increase the feeling of guilt; if someone felt rejected and unloved he should have visitors so he wouldn't feel this way. He should be permitted to gain support and reassurance from his visitors. Some visitors try to encourage patients into activity before they are emotionally ready; this can deepen depression. Some doctors stated that only relatives and close friends should be allowed, as acquaintances may come only to satisfy curiosity and to spread gossip. An individual's acceptance in the community could be destroyed if acquaintances saw him in acute stages of illness where he had lost control.

One doctor stated that if it were advisable for a patient to maintain contact with his former environment, visitors should be allowed only once a week. Three interesting comments were made regarding visiting on a once-a-week basis. The patient would anticipate a visit with pleasure. If he did not wish to receive visitors, there is only one day a week when he has to worry about it and have feelings of guilt because he rejected or wished to reject them. Also, a better evaluation of the patient's progress toward handling social situations can be made.

An overall value was that visitors helped the patients to maintain con-

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tact with reality, to better handle social situations and to become rehabilitated.

A side-effect of visiting hours in a psychiatric hospital is public education. They see the various types of patients and realize that they do not appear to differ greatly from people met in everyday life. They begin to understand that many patients do return to a normal way of life. The visitors are able to go to the patients' rooms. They are reassured that the patients are comfortable in the hospital.

In interviewing graduate nurses, they gave the following responses:

It was generally conceded that the patients should have visitors though visiting hours should be regulated to meet the individual patient's needs. About 30 per cent of the nurses thought there should be visiting hours every day; the rest believed that every other day would be sufficient. The latter group felt it too exhausting for the patients thus keeping them from making full use of the planned hospital activities. Another opinion was that the patient could become too dependent on visitors thus preventing him from learning how to be independent.

One nurse stated that the patients should not have visitors for a week following admission. The patients could then adjust to the hospital and establish a routine before having to adjust to visitors. On the other hand, another nurse thought that open visiting hours should be established so that following favorable advantages might result:

> Visitors would not stay as long when they knew they could come at any time; patients would not wait for visitors at established times and then be disappointed if no one arrived; patients who received no visitors would not become as disturbed as they would if the majority of the patients had visitors at one time.

Most nurses thought that open visiting hours would not be satisfactory. Some disadvantages stated were:

> Patients needed an established routine and it would be disturbing for them to receive visitors throughout the day; they would continually wait for visitors and perhaps refuse to take part in organized hospital activities.

It was generally agreed that visitors keep the patient in contact with reality. At times visitors may be a help to the hospital staff. For example, they may be able to confirm information that the patient has given about delusional patterns and personal traits. Also, if a patient sees that his relatives have confidence in the hospital, he may follow their example and form a more confident relationship with the staff. On occasion, a visitor may help to calm the patient, particularly if there is a language barrier. Visitors help the patient to occupy some time and give them a reason for consciousness of their personal appearance.

The nurses seemed to agree with the doctors that visitors helped the patient to maintain an interest in life. Visitors give support to the patient and in many instances help him to realize that he is not being rejected. The nurses noted that visitors help make the patient aware that he has to behave in a manner which is acceptable. This helps in his ultimate rehabilitation.

Conversely, there are disadvantages in patients having any visitors. Sometimes, a relative will so identify himself with the patient, that he gains incorrect ideas regarding the hospital and then interferes with treatment. Patients tend to develop a feeling of dependence on visitors and become depressed if they do not arrive when there are visiting hours.

Visitors exhaust some patients. On occasion a visitor so sympathizes with an acutely psychotic patient that he is persuaded to take the patient home. Anxious relatives may pass on their anxiety. Some patients, such as schizophrenics, have strong negative feelings towards their parents so that their presence will interfere with treatment. Visitors should be instructed regarding the best approach to the patient and should be told in what condition they will find him.

Opinions differed about whether evening visitors helped promote the evening program. In theory, it was thought to be a good idea to have the relatives and patients join in the activities together. In practice, it was noted that patients preferred to remain on the ward with their visitors. Frequently they used the excuse that they were waiting for company so they wouldn't have to participate.

The group social worker stated that

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visitors should stimulate the evening program. For instance, it would be natural for a man to attend the dance with his wife. The worker believed this would be an excellent form of public education because the general public could see that the psychiatric patients participate in normal activities.

As for visitors interfering with occupational therapy, the therapist stated that if the patients were interested in the therapy, they could receive their visitors in that department.

It is apparent that the subject of visitors in a psychiatric hospital is very complex. Questions must be answered on an individual basis. There is no overall agreement as to how soon the patients should be allowed to receive visitors after admission nor how frequently visitors should be allowed to come. It is agreed that visitors do help the patient to maintain contact with reality and community life. It is recommended that visitors be instructed about how to approach the patient, so as not to interfere with the general planned program.

Hebephrenic Schizophrenia

Sister Marie Elise, f.d.j.

Schizophrenia is most common during the transition period between adolescence and early adulthood. It may occur later in life as this case study shows.

Social and Personal History

Miss Mary Roy, aged 49, was one of three girls in a family of five. Her father was a farmer and until 10 years ago she lived at home. Her parents were third cousins, her mother having died some years previously following paralysis. There is no known mental illness in the family history.

According to Miss Roy, her childhood was uneventful but she has always felt that she was the least loved of the children. She completed Grade VI and had no difficulty with school work.

Miss Roy is quiet, almost docile. She has no friends, preferring to stay at home, becoming increasingly reserved and timid. She attends church with her family but is not particularly religious. Most of her time is spent alone—in a rocking chair listening to the radio. She has no hobbies and is not interested in any games. She has never shown any interest in the opposite sex.

Her menstrual periods began when she was 14 and have always been preceded by lower back pain and irritability.

Sister Marie Elise is a student nurse at the Hôtel Dieu Hospital in Quebec City.

History of Present Illness

Miss Roy's illness began when she was 35 years of age. Eight or ten days before the onset of her menstrual period she displayed personality changes, and became disinterested in her usual activities. Ten years ago she was hospitalized for hebephrenic-catatonic schizophrenia. She was treated with Largactil 50 mg. t.i.d. and Phenergan 50 mg. at bedtime.

Two months later on discharge, she was much improved. She stayed in the city to work as a domestic. She was a good worker, though slow, and remained with the same employer until six months ago when she returned to her brother's farm. During the past six months her symptoms have recurred. Her condition became increasingly worse until it was impossible to care for her at home. A sister gave the following history:

> Each month prior to her menstrual period her behavior changes. She has high blood pressure and will not follow her diet. If anyone suggests or insinuates that she ought to, she becomes angry.

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She cannot bear to be contradicted. She will never do anything that she is asked, in fact, usually does the opposite.

During these periods she rarely eats or sleeps. She mumbles all night — talking or singing to herself. She may spend the night walking either in the house or out of doors. She does not care for herself — neither washes nor keeps her hair tidy.

Without provocation she tears my clothes to pieces, hits me and pulls my hair. Her emotions are confused. She is reckless; she rarely cries though she frequently laughs to herself. She is often incoherent during these episodes.

When her menstrual period begins she becomes quiet — in several days she seems almost normal. This pattern is repeated each month.

Physical History on Admission

Miss Roy has frequent headaches and fainted once. She has had no other illnesses.

On admission, the patient responded poorly to questioning and mumbled to herself. Her speech was inarticulate and incoherent; her ideas fantastic and changeable; her responses were inaccurate, slow, spoken without conviction. She seemed to be indifferent; thinking of other things.

Mental Capacity

She was moderately well oriented as to time and place. Her memory for past events was good, but for recent events poor. She tried to enclose herself in a world of her own; she was not interested in those around her; she was completely autistic. Her judgment was poor; she was not self-critical. Some time later she acknowledged that she required hospitalization.

Observation of the Patient

Miss Roy's deportment on admission was bizarre. She held herself immobile, numb, expressing no emotion, no perception; she seemed a stranger to the external world. She appeared neglected and wore a shabby dress. Her facial expression in particular was peculiar; her eyes were half closed, she was pouting and conveyed an expression of stupidity.

At first she was silent, then slowly and with difficulty she answered questions. She felt that the world was against her, her brother especially. She was slightly incoherent.

Being in the hospital did not seem to affect her. Her complete indifference was marked. She was quite inactive, showing interest in nothing. She slept well with medication, her appetite was good, her moods variable. When she was encouraged and helped to mix with the other patients she did not respond.

Occasionally she would notice those around her and then return to solitude. She answered when spoken to, but never asked questions or started a conversation.

To outward appearances — she was a quiet patient, who sometimes lay still for several hours with a blank expression on her face. She did not seem to be thinking — she showed no emotion.

Treatment

Medications rather than electric shock therapy were the doctor's choice. From the beginning of her hospitalization she received the same drugs she had been taking at home. There was steady improvement in her mental state. When she was not given her drugs for a trial period, the symptoms recurred within eight days. She took her medications without hesitation.

Her blood pressure decreased as a result of the tranquillizers. It was maintained at 130/80. She ate well and never complained of physical pain. She always said that she felt well.

Progress

The bizarre ideas gradually disappeared, although marked emotional indifference remained. Alternately she appeared agitated and stupid. The self-criticism became more real. In general her deportment was better.

Prognosis

Most patients with this condition have a recurrence of symptoms. On the other hand, if Miss Roy takes her medications faithfully she may have continued remission as she had for ten years. She is capable of gainful employment again. She accepts the situation and is not disturbed about the future.

It is important for this patient to follow the directions of her doctor carefully and to visit him regularly.

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I have been climbing the professional totem pole, one academic degree after another. But is this nursing?

While I am in committee meetings discussing whose duty it is to chart temperatures, my patients are doing without good old-fashioned nursing care.

The child with a skull fracture doesn't care one whit whether I took a baccalaureate degree in philosophy, or even a master's. Her immediate need is to be comforted, to feel a sympathetic presence. She needs medication, too; and I am able to administer it in the prescribed fashion because I am a *nurse*.

Nursing was once a pyramid with a broad, firm foundation of general staff nurses who practised their profession faithfully because they were dedicated to service. Only a few at the top handled management detail.

Gradually we have inverted the nursing pyramid. The now broad top is peopled by a growing multitude of administrators, coordinators, managers, expediters, directors, and consultants — all of them far, far removed from the patient. At the bottom is an ever-slimming base of staff nurses. Isn't it about time we took a look at what is happening?

Graduating students are seldom encouraged any more to enter staff nursing with the idea of making it a specialty. Instead, staff nursing is looked on as a stepping stone to the "higher" positions.

Why not give the dedicated staff nurse opportunities for advancement in status and salary in her chosen field — rather than make her feel like a backslider because she does not aspire to be a supervisor?

More and more weight is now put on academic learning. Less and less is put on practical application of that learning. With the 40-hour week, the student's bedside practice was reduced; but at the same time her classroom hours were increased.

I would like to see young graduates required to give at least one or two years to staff nursing before being permitted to apply for administrative jobs or even to enter advanced courses in nursing education. (A senior student at a large hospital in the Midwestern United States recently received her appointment as an assistant director of a nursing service three weeks before she had received her diploma!)

I would further like to see every member

(See page 267)

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Nursing Profiles

Kathleen Elizabeth Arpin has been appointed assistant director nursing education of the School of Nursing, Toronto General Hospital. She replaces Helen (McLaren) Rafuse who resigned from the position shortly prior to her marriage.



KATHLEEN ARPIN

Miss Arpin is a graduate of St. Joseph's Hospital, London and holds her Bachelor of Science degree in nursing education from the University of Western Ontario. Following graduation she spent a number of years on the staff of the University Hospital, Ann Arbor, Michigan. During 1954-58 she was assistant director of the school of nursing, Metropolitan General Hospital, Windsor. Immediately preceding her present appointment she was employed as a nursing education supervisor at T.G.H.

While she was working in Windsor, Miss Arpin took an extremely active interest in the local chapter and district activities as a committee member and member of the district executive. She enjoys her record collection and she also has a yen for travel.

Patricia Mary Neville is now nurse consultant to the Alberta Civil Defence Staff. Born and educated in Ottawa, she was employed by the City of Ottawa Recreational Department and later by the British Government Technical Mission, United Kingdom and Canada, during the first years of World War II. Following this, she entered training at St. Joseph's General Hospital, Peterborough. Since her graduation, she has done operating room work at the Royal Ottawa Sanitorium, public health nursing in the rural areas of Ontario and emergency nursing in the Vanderbilt Clinic, Presbyterian Hospital, New York City. Most recently she has been on the staff of the Misericordia Hospital, Edmonton as charge nurse in the emergency department. Miss Neville will assist in the further development of civil defence services in Alberta.

Brian Watkin has joined the staff of *Nursing Times,* London, England, as an assistant editor. A graduate of Ipswich Borough General Hospital, he is a nurse turned journalist. Formerly connected with a firm of medical publishers as a sub-editor, he has also had experience as the assistant editor of a political weekly and as a freelance writer on nursing and health service topics. He has been a contributor to *Nursing Times* since his student days and has been a first prizewinner in essay competitions on two different occasions.



SISTER STE SOLANGE FOUQUET

Sister Ste Solange Fouquet, a member of the order of the Sisters of St. Francis of Assisi, has been made a Fellow in the American College of Hospital Administrators. The honor was conferred upon her at an impressive ceremony held in the Metropolitan Opera House, New York.

Sister is a graduate of Hôpital St. François d'Assise, Quebec City and of Laval

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By LUELLA J. MORISON, R.N., M.A., Nursing Education Consultant, Ohio Department of Mental Hygiene and Correction; formerly Director of Nursing Education and Student Guidance, Mt. Carmel Hospital School of Nursing, Columbus, Ohio. Ready in March, 1960. 3rd edition, approx. 384 pages, 8¼" x 10½". About $4.75.

Have you been seeking a book which can improve your students' ability to meet their personal and professional responsibilities? The new 3rd edition of Mrs. Luella Morison's combined text and workbook can be even more valuable to the student nurse — and to those who guide her educational opportunities — than the first two editions in the following respects: Greater emphasis has been placed on the development of her understanding and acceptance of self as a person and in acquiring knowledge, skills and appreciations of nurse-patient relationships. Current information, data, and trends have been added for the student approaching graduation. New tools have been made available to the student for the utilization of self in patient care and integration of mental hygiene principles. All reference lists have been revised and a new index serves as a quick reference for content.

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New 7th Edition

Smith CARTER'S MICROBIOLOGY AND PATHOLOGY

By ALICE LORRAINE SMITH, A.B., M.D., Pathologist, J. K. and Susie L. Wadley Research Institute and Blood Bank, Dallas, Tex. Just published. 7th edition. 725 pages, 6¾" x 9½", 316 illustrations. Price $7.50.

Designed for use in courses in "General Pathology" or "Introduction to Medical Science" in schools of nursing offering a diploma program, this thoroughly revised and modernized book places emphasis on the mechanisms of disease and organisms. The author, an outstanding physician and pathologist, provides an up-to-date discussion of recent advances in the field including new antibiotics and newly available methods for inhibiting or destroying microbes. A new chapter deals with injury produced by nonliving agents and includes a discussion of nuclear medicine and radiation pathology.

New 2nd Edition

Fagothey RIGHT AND REASON

By AUSTIN FAGOTHEY, S.J., Professor of Philosophy, University of Santa Clara, Santa Clara, California. New. 1959. 2nd edition. 627 pages, 5½" x 8½". Price, $6.00.

Written especially for a full-year, Catholic orientated college course in ethics, RIGHT AND REASON gives students a clear, practical understanding of the current ethical problems of everyday life. This book provides a modern presentation of the Aristotelian-Thomistic interpretation of ethics from the "problem" method rather than the "thesis" method. Each chapter covers historical background on a problem, alternative philosophies and arguments and a concise summary of the investigation. You will find this new 2nd edition extensively revised — the topics of happiness and the end of man have been rewritten to clarify the philosophical approach and distinguish it from the theoretical; reflections on logical positivism, relativism and existentialism have been introduced; and the terminology simplified.

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University. She later became the administrator of her home hospital for a period of 12 years. She is now the superior and director of nursing at Hôpital Ste Jeanne d'Arc, Montreal. Our congratulations and good wishes are extended to her.

In Memoriam

Ella Marie Ronnow Andersen who graduated from Den danske Diakonissestiftelse, Copenhagen, Denmark in 1948 died during 1959.

* * *

Madeline Orr Armour, a graduate of the Royal Infirmary, Glasgow, Scotland in 1925 died during 1959. She had engaged in occupational health nursing and for some years she was on the staff of the Forest Ranger School, Dorset, Ontario.

* * *

Lottie (Yaneosiski) Bush who graduated from St. Paul's Hospital, Vancouver in 1913 died during 1959.

* * *

Gladys B. Carter, a graduate of King's College Hospital, Surrey, England died on December 7, 1959. Prior to obtaining her nursing preparation, Miss Carter had been a lecturer in economics and practising midwife. Following the war she came to the University of Toronto School of Nursing as a lecturer. Later as the first holder of the Boots' Research Fellowship, University of Edinburgh, she helped develop plans for the new Nursing Studies Unit. She was also a nurse consultant to the Second Expert Committee on Nursing, World Health Organization.

* * *

Josie (Gibson) Conway, a graduate of St. Michael's Hospital, Toronto in 1917, died on September 11, 1959. Following her graduation, she worked with the Department of Health, Toronto for a time.

* * *

Gladys (Pepino) Dawson, who graduated from Oshawa General Hospital in 1917 died in the spring of 1959. During her professional career she had engaged in private nursing.

* * *

Zella Viola Douglas, a graduate of Toronto General Hospital in 1925 died on December 5, 1959. She had engaged in private nursing during her professional life.

* * *

Eugenie Le Noblet Duplessis, a retired Quebec nurse, died on December 10, 1959. She was 86 years of age. At the start of World War I she joined the Canadian Army Medical Corps as a member of the Winnipeg Ambulance Unit. Later she enlisted in the active force and went to France where she served as an assistant matron. In recognition of her services, she was awarded the General Service Medal and the Victory Medal. Following her return to Canada, she joined the Department of Indian Affairs and was posted to a reservation at Nanaimo, B.C. She remained there until her retirement in 1942.

* * *

Frances White (Phelps) Foote who graduated from the Toronto Western Hospital in 1939, died on October 29, 1959.

* * *

Mae Leafa (Linn) Gould, a graduate of the Nicholl School of Nursing, Peterborough Civic Hospital in 1938, died on May 17, 1959. She had engaged in private nursing.

* * *

Marion Janet Herriman who graduated from Kingston General Hospital in 1945, died November 24, 1959. She was employed in institutional nursing.

* * *

Lillian I. Lawrence, a graduate of St. Luke's Hospital, New York died on December 28, 1959. Many years ago she was on the staff of the Toronto Department of Health.

* * *

Luella McKnight, a graduate of Oshawa General Hospital in 1924, died on September 27, 1959 after a long illness. She had devoted her professional life to private nursing.

* * *

Rita (Marwood) Pauline who graduated from St. Joseph's Hospital, Victoria in 1919, died recently in Vancouver.

* * *

Margaret (McKenzie) Pitts who graduated from St. Joseph's Hospital, Victoria in 1920, died recently.

* * *

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Victoria Hospital, Montreal in 1922 died suddenly on December 4, 1959. She was a United Church missionary nurse in China for almost 21 years and, prior to her retirement, was matron of the United Church Hospital, Burns Lake, B.C.

* * *

Mary Margaret (Curtis) Ruddy, a graduate of Oshawa General Hospital in 1941 died on September 20, 1959. Following graduation she was head nurse in the admitting and emergency department of her hospital for several years. Later she became assistant superintendent and eventually associate director of nursing service.

* * *

Sister Mary Romanus (Pearl Hushin) who graduated from St. Joseph's Hospital, Toronto in 1933 died during July, 1959. She was engaged in institutional nursing.

Book Reviews

Psychology as Applied to Nursing by Andrew McGhie, M.A. 247 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 1959. Price $3.00.

Reviewed by Mrs. C. Yannikosta, Clinical Instructor, University Hospital, Saskatoon.

The author states in the preface that his aim is to introduce psychology to the student nurse in a manner that will make its study as painless as possible. The need for and importance of this subject in preparing the nurse to give more effective care to her patients and to gain a better understanding of her own personality is well recognized by modern nurse educators.

This book is presented primarily as a basic introduction to psychology for the student nurse. Certain specific areas must be supplemented by reference reading in order to reach the desired comprehension of the subject under discussion. The author has succeeded in presenting his material in a very effective and stimulating manner. He "talks" to the nurse, using many examples and anecdotes to illustrate and to emphasize his material. Simple, non-technical terminology is used whenever possible and definitions are moderately numerous.

The content seems to be structured in the most logical, practical way possible. The author begins with a study of human behavior progressing from the infant to old age. This is followed by a discussion of the forces that motivate individual behavior, the interaction of environment and a study of the individual as a social being.

At the end of each chapter there is a short summary entitled "Concluding Remarks." This should be of great value in helping the student to assimilate the highlights of each section. Suggested questions at the end of the chapters provide excellent teaching material as out-of-class assignments or for discussion groups.

This appears to be a satisfactory text for student nurses and a helpful guide to the instructor who teaches an introductory course in psychology.

Medical and Surgical Nursing Part II by Amy Frances Brown, R.N., B.Ed., M.S. in N., Ph.D. 850 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 1959. Price $8.00.

Reviewed by Miss P. McBride, Winnipeg General Hospital, Winnipeg, Man.

The author's objective was to provide the nursing student with a compact text dealing with advanced medical and surgical nursing or the so-called "specialties." These have all been adequately discussed.

Approximately one-third of the content deals with infectious diseases. There is much detail in this area that will not be of too much value to the student nurse in Canada. The remainder of the material, however, is excellent. The discussion of medical and surgical emergencies is particularly useful and timely. It will provide both the student nurse and the instructor with concrete information.

Charts and graphs have been used to good advantage. The statistics presented in this manner come alive to the reader and are more meaningful to her. Photographs and illustrations have also been included effectively to emphasize specific points and descriptions. The area on dermatology is particularly well illustrated. Case histories help to make the content more vivid.



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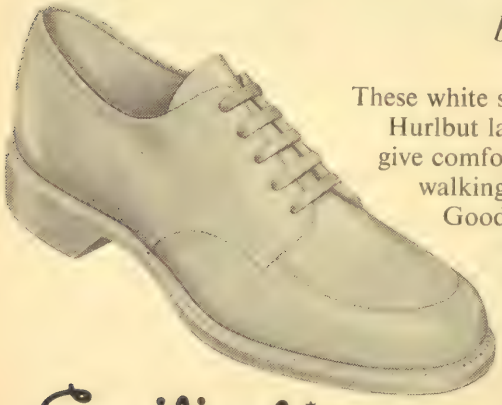
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Both student nurses and instructors should find this book very helpful, both as a text and for reference purposes.

Orthopaedic Nursing by Mary Powell, S.R.N., M.C.S.P. 464 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 3rd ed. 1959. Price $4.70.

Reviewed by Miss Ruth Kelsall, Winnipeg General Hospital, Winnipeg, Man.

The author states that "this book is written primarily for nurses and physiotherapists working in orthopedic hospitals . . . It is hoped that it will prove useful to those engaged in orthopedics in the wards and departments of general hospitals, and to those working in sanatoria . . ."

The content is introduced with a discussion of the basic principles involved in orthopedic treatment. This includes positioning, traction, physiotherapy, plaster of Paris techniques, splints and appliances.

The necessary nursing care involved in each of these areas is outlined. The introductory section is followed by detailed descriptions of the various orthopedic conditions. The author gives particularly good attention to the specific nursing care required.

There is a large section devoted to the care of patients with tuberculosis of bones and joints. Even though this condition is now seen with less frequency in some countries the author feels that the same basic principles for nursing these patients can be of benefit to the nurse as she works with those who have other orthopedic conditions.

There are many good illustrations and diagrams. However, as this book was written in England, some of the equipment shown appears to be more specific to England than to Canada. There is no discussion of the Stryker frame and some of the developments in orthopedics. The book is most valuable in giving the nurse a sound understanding of the basic principles in orthopedic nursing, but it does not inform her of the more recent developments in this field in Canada.

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* * *

In 1959 Canadian Jewry celebrated its 200th year of settlement in Canada, and the entire Jewish community undertook to fittingly commemorate this most auspicious moment in its history.

Canada's history is a history of the immigration of the multitude of ethnic groups which arrived to embrace the opportunities it offered. The love of country borne by these immigrants and their descendants and the individual dignity bestowed upon them has evolved to give to the modern world a nation known as "Canada" and its inhabitants who proudly bear the distinctive title of "Canadian."

In acknowledging the 200th year of Jewish settlement in Canada, much will be noted of the achievements made by individual members of the Jewish community and of the contribution the community, in general, made towards Canada's flowering as a nation in its own right. However, the theme overshadowing all was the constant awareness that there existed a land that had made all of this possible. That in this land ideals and dreams were not only brought to fruition but became an integral part of its heritage. The Bicentenary Year was one of gratitude and thanks to their country on the part of its citizens of the Jewish faith.

— *JIAS News,* October, 1959

* * *

One always begins to forgive a place as soon as its left behind.—Charles Dickens

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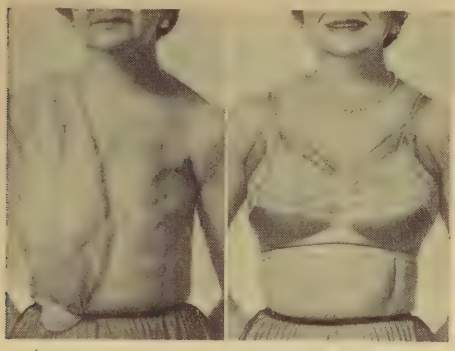
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A Poem for Probationers

The skeleton hangs in the classroom,
His bones are plain to view
Do you ever think he once had a heart,
And warm-blooded flesh, like you?
Do you ever think as he hangs there,
So dumb to student fears,
That he once studied anatomy,
And probably shed tears?
So while he swings so merrily,
Give thought to the former man
Did he ever dream he would rattle?
Study his bones if you can!
One of those days your bones may swing,
For some inquisitive clan!

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* * *

Look beneath the surface; let not the several quality of a thing nor its worth escape thee. — LAERTIUS

* * *

Let there be spaces in your togetherness.
— KAHLIL GIBRAN

* * *

Have you had a kindness shown? Pass it on. — HENRY BURTON

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Nightingale School of Nursing

Arthur J. Swanson, F.A.C.H.A., has been appointed chairman of the Board of Trustees of the new Nightingale School of Nursing. The school, which is being developed under the auspices of the Ontario Hospital Services Commission, will be located in central Toronto. It will be opened in September, 1960.

The purpose of establishing the school is to improve the quality of nurse education while helping to alleviate the shortage of nurses by giving a two-year course. It will be modeled on the program of Toronto Western Hospital School of Nursing, but will omit the one year of internship.



ARTHUR J. SWANSON

The advisory committee is made up of the following members: Sidney Liswood, administrator, and Ella Howard, director of nursing, New Mount Sinai Hospital; Nettie D. Fidler, director of the University of Toronto School of Nursing; Dorothy Riddell, senior inspector, nursing branch, Ontario Department of Health; Gladys J. Sharpe, senior consultant in nursing, Ontario Hospital Services Commission, and M. Blanche Duncanson, director of the new school.

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International Trends in the Birth Rate

In many countries throughout the world the birth rate has fallen almost continuously from the relatively high levels reached in the immediate postwar years.

Finland experienced a sharper decrease in birth rate than any other country in Europe; the rate there fell one third — from 28.0 per 1,000 population in 1947 to 18.5 in 1958. Over the same period, Sweden, Denmark, the Netherlands and Czechoslovakia recorded reductions of about one quarter.

Very likely as a consequence of improved economic conditions, the birth rate in England and Wales has turned upward in recent years. After falling from 20.5 per 1,000 in 1947 to 15.0 in 1955 the rate rose to 16.4 in 1958. Last year's rate was higher than the 15.1 per 1,000 recorded in 1938, the last prewar year. Scotland shows a trend similar to that for England and Wales. The birth rate in recent years has also tended upward in West Germany, rising from a postwar low of 15.8 per 1,000 in 1953 to 17.0 in 1958. At the same time, the rate in East Germany decreased from 16.4 to 15.6 per 1,000.

Japan is probably the only country in the world to have reduced its birth rate by about one half between 1947 and 1958; in fact, the annals of vital statistics record few instances in which so marked a decrease occurred in so short a period. The birth rate in Japan dropped without interruption from 34.3 per 1,000 in 1947 to 17.2 in 1957, rising only fractionally to 18.0 in 1958.

Contrary to the experience for many other countries, Canada, the United States, Australia, and New Zealand have experienced a protracted baby boom. In these countries the birth rate in the past decade has been approximately one third greater than that recorded just prior to World War II. In all four countries, the annual number of births in recent years have broken all previous records. There are no indications that the baby boom in the four countries will end shortly.

In many large and populous areas of the world birth statistics are either lacking or so deficient that they are of very limited value. India, for example, reported a birth rate below 25 per 1,000 in 1957, but this is an understatement of the actual situation, resulting from the marked underregistration

of births. No reliable figures at all are available for the mainland of China, which is believed to have a population exceeding 650 million.

It is unfortunately not possible to trace the postwar trend of the birth rate in the Soviet Union because of the lack of adequate data. Birth rate figures released by that country for the period 1950-57 show a slight downward trend; in 1950-51 the rate was 26.7 per 1,000 and in 1956-57 it was 25.2.

— *Statistical Bulletin,* Metropolitan Life Insurance Company

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(Continued from page 251)

of every administrative nursing staff (both in nursing service and in nursing education) required to spend at least one day a year in actual patient care, either as a member of a nursing unit team, or as a private nurse. What new life this would bring to nursing! We would begin to see less emphasis on curriculum and more on character building, less concern over the nursing-hours-per-patient formula and more concern over the human equation.

There abideth these three: nursing administration, nursing service, and nursing education. But the greatest of these is NURSING.

MARGARET HELEN ANDERSON, R.N.

Reprinted from *International Nursing Review.*

* * *

In the Massachusetts General Hospital, Boston, a new system of rehabilitation has been started using the nonprofessional services of the hospital — the kitchen, barber's shop, carpentry shop, accountancy department, and so on. The occupational therapist is in close consultation with the foremen of the various departments who supervise and assess the work of the patients who are being rehabilitated in their department. The object of the scheme is to enable the patient gradually to regain his interest in work and to tolerate a full eight-hour working day.

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* * *

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*(excessive mucus discharge)

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General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

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Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

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Registered Nurse to act as Matron in 10-bed rural hospital. Minimum salary $320 per mo. For full particulars apply to: Secretary-Treasurer, Box 235, Fisher Branch, Manitoba. **Matron** for small hospital near Riding Mountain National Park. Salary $325-$350 depending on experience. Full maintenance provided at $45 per mo. Duties to commence April 15th. 1960. Reply giving nursing references & experience to: Matron, Medical Nursing Unit, McCreary, Manitoba.

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General Duty Registered Nurses for well-equipped modern 32-bed hospital, excellent personnel policies. Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

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DIRECTOR OF NURSING for modern, approved 100-bed hospital at present considering expansion. Experience either as director or assistant preferred & postgraduate training in administration an advantage. No school of nursing. Salary open. Excellent personnel policies include 40-hr. wk., pension plan, sick leave accumulative to 30 days, 4-wk. vacation after 1-year service, 8 statutory holidays. Apply giving full details of training & experience, salary expected, etc., to: Administrator, Civic Hospital, North Bay, Ontario.

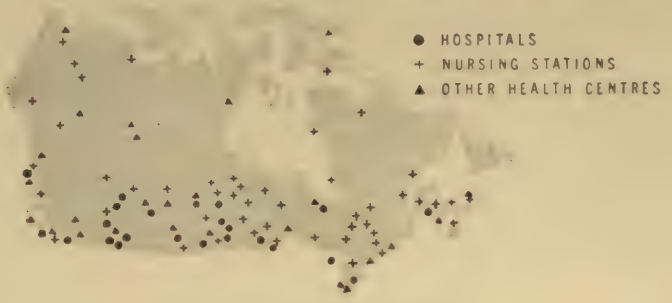
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(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

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Registered Nurses 2 (Science Instructor & Nursing Arts Instructor) for school of nursing—60 students. Good working conditions. Inservice education & recreational programs. Write to: Directrice de l'école d'infirmières, Hôtel-Dieu du Christ-Roi, Alma, Lac-St-Jean, Québec.

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Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

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Head Nurse — Operating Room in a modern 80-bed hospital. Basic salary $310 with recognition for P.G. courses, university training & for previous experience. 40-hr. work wk., good personnel policies, residence available. Apply: Director of Nurses, Weyburn Union Hospital, Weyburn, Saskatchewan.

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U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

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Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write: Personnel Office, Sutter Community Hospitals, 2820 - L Street, Sacramento, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses Surgery & General Duty for newly expanded 200-bed hospital located in Southern California. Starting salary $315 per mo. with $10 differential for obstetrics, surgery & night duty, 40-hr. wk. Progressive community near Disneyland. Contact: Director of Nurses, Miss E. F. Horton, Santa Ana Community Hospital, 600 East Washington Avenue, Santa Ana, California.



Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$340-$372.50* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

CALIFORNIA STATE HOSPITALS CALLING...

REGISTERED NURSES FOR IMMEDIATE EMPLOYMENT

- STARTING SALARIES $376 WITHOUT EXPERIENCE, $395 WITH ONE YEAR PSYCHIATRIC NURSING
- STIMULATING AND CHALLENGING CAREERS
- CHOICE OF LOCATION
- PROMOTIONAL OPPORTUNITIES
- REGULAR SALARY INCREASES
- LIBERAL EMPLOYEE BENEFITS

•

Eligibility for California License
and
Possession U.S. Declaration of Intention Required

•

Write Mrs. Katharine Steele

DIRECTOR OF NURSING SERVICES, DEPARTMENT OF MENTAL HYGIENE
1320 KAY STREET, SACRAMENTO 14, CALIFORNIA

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Operating Room Supervisor for 230-bed progressive J C A H General Hospital in rapidly growing town of 40,000. Salary $4,700 - $6,000 pending professional background. 40-hr. wk., week-ends free; liberal policies. Fully accredited N L N school of nursing of 50 students; faculty status B.S.. desired and/or postgraduate study required. Located 65-mi. from New York city in foot hills of Berkshires. Write: Mrs. Elsa L. Brown, Assistant administrator, Nursing, Danbury Hospital, Danbury, Connecticut.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 400-bed, non-sectarian General Hospital affiliated with Medical School. New salary rates $370-$400 days & $400-$430 afternoons & nights per mo., 40-hr. wk., comfortable, low cost living accommodation in attractive residence building. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th, Place, Chicago 8, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses for 85-bed voluntary non-profit hospital in growing community of 11,000. Basic salary $295 per mo. with increments of $5.00 every 6-mo. up to 2-years; 40-hr. wk.; 7 paid holidays, sick leave accumulative to 48-days; $17.50 premium for 3-11 shift, $15 additional for 11-7 shift. Apply to: Director of Nurses, St. John's Hospital of Red Wing, Red Wing, Minnesota.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

JEWISH GENERAL HOSPITAL

Montreal, Quebec

NURSING OPPORTUNITIES

Completion of expansion program makes available attractive positions for Registered Nurses for General Duty & also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations & commensurate with experience & education. Limited number of bursaries available for post-basic study after 1 year's service. Residence accommodation in very pleasant surroundings. Within 50 miles of Laurentian holiday & ski resorts.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3,860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Registered Nurses, General Duty & Operating Room (All areas & shifts available) for 165-bed JCAH Hospital, new 50-bed addition to be opened in March. Starting salary $305 General Duty, $320 O.R. 40-hr. wk., 2-3 wk. paid vacation, sick leave, nurses' residence available at reasonable rates. Excellent shift differentials. Apply: Director of Nursing, Memorial Hospital, Cheyenne, Wyoming.

Registered Nurse for 20-bed General Hospital located near San Francisco. Salary: $320-$335 per mo. 40-hr., 5-day wk., rotating shifts. Vacation with pay. Meals & room at hospital reasonable. Apply: Administrator, P.O. Box B., Gustine, California.

ONTARIO

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk., good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

ALBERTA

Instructors of Nurses to teach students in 3-yr. psychiatric nursing program for 1,500-bed approved active treatment hospital. Salary range: $4,320 to $5,160 per yr. 40-hr. wk., civil service holidays, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply, stating qualifications & experiences to: Superintendent of Nurses, Provincial Mental Institute, P.O. Box 307, Edmonton, Alberta.

MANITOBA

Registered Nurse over 30 years with at least 5-yr. experience & some administrative ability to act as Matron for modern 60-bed hospital. Salary: $360 with increments. Good living quarters. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered Nurses for Swan River Valley Hospital. Salary: $280 with 4 semi-annual increments to $300. 44-hr. wk., 3, 8-hr. rotating shifts. 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Daily bus service to points — north, south, east & west. Local golf club, flying club, curling club; good swimming, fishing, skating, etc. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for R.N's., min. $268 - max. $304 per mo.; L.P.N's, min. $208 - max $230 per mo. 8-hr. duty (day, evening or night), 40-hr. wk. Must be registered or licenced in Manitoba. Apply in writing to: Director of Nursing, Municipal Hospitals, Winnipeg 13, Manitoba.

NEW BRUNSWICK

General Duty Nurses (medical, surgical & obstetrical floors). New nurses' reesidence completed in May. Apply: Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

Dietitian for 75-bed hospital. Small school of nursing. Apply: Superintendent, Carleton Memorial Hospital, Woodstock, New Brunswick.

SASKATCHEWAN

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry, $37 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Operating Room Supervisor with postgraduate course in operating room technique for 225-bed hospital with school of nursing. Good personnel policies. Apply: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

TEAM NURSING IN THESE HOSPITALS!



Head Nurses • Assistant Head Nurses • Team Leaders

Qualified by professional training and personality to provide administrative guidance and high quality bedside care.

Salaries at the rate of $6,420 - $5,340 - $4,860 per year depending on experience and training. Annual increases. 40 hour week. Shift differential where applicable. 4 weeks vacation. 7 paid holidays. Laundry of uniforms. Social security plus non-contributory retirement plan.

General Duty Nurses at the rate of $4,440 per year.

Write to:

MINERS MEMORIAL HOSPITAL ASSOCIATION
BOX 61, WILLIAMSON, WEST VIRGINIA, U.S.A.

GENERAL DUTY NURSES

NURSING ASSISTANTS

for all departments in a new 107-bed, 40-bassinet hospital. Gross salaries: Registered Nurses - $275. Nursing Assistants - $175. 40-hour week, 3-week vacation annually. Group pension plan & residence accommodation if desired.

Apply Administrator of

ST. JOSEPH'S GENERAL HOSPITAL, ELLIOT LAKE, ONTARIO.

CHIEF DIETITIAN

Required immediately for 280-bed Tuberculosis Sanatorium.

Salary scale is $3,630 - 100 - $3,850 per annum. Excellent working conditions, 40-hour week, paid annual leave, sick leave benefits, etc. Accommodation is available if required, for which $44 per month is deducted from salary.

Applications stating age, qualifications etc. should be addressed to:

SECRETARY, ST. JOHN'S SANATORIUM, ST. JOHN'S, NEWFOUNDLAND

GUYS-MAUDSLEY NEUROSURGICAL UNIT

LONDON, ENGLAND

Applications are invited for the post of Theatre Sister and Staff Nurses in the above Unit. Good previous experience is necessary.

Applications to:

THE SUPERINTENDENT OF NURSING, MAUDSLEY HOSPITAL, DENMARK HILL, LONDON, S.E.5, ENGLAND.

THE VANCOUVER GENERAL HOSPITAL

requires

PEDIATRIC, OPERATING ROOM & PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff. Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department, Vancouver General Hospital, Vancouver 9, British Columbia.

REGISTERED NURSES REQUIRED

(General Duty and Operating Room)

Modern 52-bed hospital 50 miles from Ottawa in the heart of holiday resort area has openings. Commencing salary $240 per month ($10 extra night duty two weeks) all statutory holidays from employment date, three weeks annual vacation, straight 8-hour day, 44-hour week.

Private accommodation in luxurious new residence with full board and all facilities including laundry. ($25 per month only deducted for residence accommodation).

Apply

DIRECTOR OF NURSING, PONTIAC COMMUNITY HOSPITAL SHAWVILLE, QUEBEC

CLINICAL INSTRUCTOR

(Immediately)

For school of 75 students, 1 class yearly. Salary schedule in conformity with RNAO recommendations. Attractive residence accommodation.

Write: Director of Nursing,

ST. JOSEPH'S HOSPITAL, SUDBURY, ONTARIO.

MANITOBA

Registered Nurse (for duties of Matron), Registered Nurse &/or Practical Nurse (for general duties) for 11-bed Medical Nursing Unit. Good salaries & conditions. Apply: Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

ONTARIO

Registered Nurses for general duty nursing in all departments of hospital. Apply: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Nurses (Operating Room & General Duty) for 20-bed private hospital. Salary: $259 per mo. plus full maintenance. Rotating shifts, averaging 42-hr. per wk. Accommodations provided in nurses' residence, single rooms. Liberal personnel policies, group ins., pension plan, 1-mo. vacation after 1-yr. service, sick leave. Excellent recreational facilities. Located in Thunder Bay district of Ontario, on main C.P.R. transcontinental line & Trans Canada Highway. Apply: Employment Supervisor, Marathon Corporation of Canada Limited, Marathon, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

BRITISH COLUMBIA

General Duty Nurse for 25-bed modern active hospital in rapidly growing vacation land. Good recreation facilities. Friendly community scenic location in mountain valley situated on Lake Windermere only 90-mi. from Banff & Lake Louise. Nursing policies as recommended by the RNABC. Full maintenance in attractive modern residence $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

Graduate Nurses (Bursaries) Salary range $324-$373 after completion of 2 year training course as Radiotherapy Technician. Bursaries available during training period. First year $2,100, second year $2,200. 5-day wk., no shift work, M.S.A. 1-mo. paid vacation each year. All statutory holidays. Applicants please state age, marital status, education & nursing experience. Apply to: Miss D. M. Findley, Director of Nursing, B.C. Cancer Institute, 2656 Heather Street, Vancouver 9, British Columbia. Telephone: Trinity 4-9321.

QUEBEC

Nurse required, married or single, living near St. Joseph Blvd. & St. Denis. Permanent employment in doctor's office, 3 afternoons & 2 evenings a week. Call: VI. 5-8653.

KINGSTON GENERAL HOSPITAL

REQUIRES

Assistant Evening and Night Supervisors, Operating Room Head Nurses, for: Neurosurgery, Ophthalmology, Ear, Nose & Throat surgery.

General Duty Registered Nurses (Male or Female), for Operating Room, medical surgical floors and Intensive Care Unit.

Certified Nursing Assistants.

For full details relating to hours, vacations & benefits, apply to:

DIRECTOR OF NURSING
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

HAMILTON GENERAL HOSPITALS

SCHOOL OF NURSING

will have vacancies
on the teaching staff
in the field of
SCIENCE AND NURSING
at the end of the school term

The school of nursing has a program of 2 years correlated theory and practice plus 1 year internship for approximately 300 students

Apply to: Director of Nursing,

HAMILTON
GENERAL HOSPITALS,
BARTON STREET EAST,
HAMILTON, ONTARIO.

SUPERVISOR CENTRAL SUPPLY

Required by

CITY HOSPITAL, SASKATOON, SASK.
(350 beds)

Qualifications — Registered Nurse, supervisory experience.

Duties — To supervise well organized central supply department with a large staff of nurses aides.
Orientation of nursing students and others to the department.

Liberal vacation with pay and accumulative sick leave benefits.

Apply to:
DIRECTOR OF NURSING
CITY HOSPITAL, SASKATOON, SASK.

GENERAL DUTY NURSES

for 82-bed fully accredited General Hospital. Salary $275 - $315, 40-hour week, no split shifts. Living accommodation in modern nurses' residence and uniforms laundered for $8.00 - $12.00 per month.

Will refund cost of railway fare to Canora, after 6-mo. service.

Apply to:
Superintendent of Nursing,
CANORA UNION HOSPITAL,
CANORA, SASKATCHEWAN.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal

WOODSTOCK GENERAL HOSPITAL
Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical, Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

PUBLIC HEALTH NURSING CONSULTANT
in Tuberculosis

required by the Division of Tuberculosis Control, Department of Public Health, City of Toronto.

Minimum requirements, advanced preparation in public health nursing, degree in nursing preferred. Special preparation or experience in Tuberculosis Nursing desirable.

Salary range $5,134-$5,991. Annual increments, 5-day week, vacation, shared hospitalization, sick pay and pension plan benefits.

Apply:

PERSONNEL DEPARMENT, ROOM 320,
CITY HALL, TORONTO 1, ONTARIO.

INSTRUCTORS
Required for

CITY HOSPITAL
SASKATOON, SASK.
(350-beds)

A nursing arts instructor and a clinical instructor in obstetrical nursing. Salary commensurate with preparation and experience. Liberal vacation with pay, cumulative sick leave, superannuation plan.

APPLY DIRECTOR OF NURSING

NURSING SUPERVISORS
required for

MENTAL HEALTH SERVICES,
ESSONDALE, PROVINCE OF BRITISH COLUMBIA
Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:

THE PERSONNEL OFFICER, B.C. CIVIL SERVICE COMMISSION, ESSONDALE, BRITISH COLUMBIA.
IMMEDIATELY. COMPETITION No. 59:152

REGISTERED NURSES
required for

MENTAL HEALTH SERVICES
B.C. CIVIL SERVICE

Starting salary $270-$292 per month depending upon experience, rising to $325 per month. Applicants must be Canadian citizens or British subjects and registered, or eligible for registration in British Columbia.

For application forms apply IMMEDIATELY to the:

PERSONNEL OFFICER, B.C. CIVIL SERVICE
COMMISSION, ESSONDALE, B.C.
COMPETITION NO. 59:608

PUBLIC GENERAL HOSPITAL
CHATHAM, ONTARIO

requires

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

for

Medical, Surgical and Obstetrical Wards

for further information

APPLY TO: DIRECTOR OF NURSING,
PUBLIC GENERAL HOSPITAL,
CHATHAM, ONTARIO.

GENERAL STAFF NURSES
WANTED

To begin January 1, 1960
Salary Reg. N. $265 gross
100-bed hospital

Write:

THE ADMINISTRATOR,
NORFOLK GENERAL HOSPITAL,
SIMCOE, ONTARIO.



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECT TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

HAMILTON GENERAL HOSPITALS

Assistant Night Supervisor

Applications are invited for the post of Assistant Night Supervisor for large obstetrical unit at the Mount Hamilton Hospital. Good salary, good personnel policies, pension plan. Living in reseidence optional.

Apply by letter giving full particulars to:

PERSONNEL OFFICE,
HAMILTON
GENERAL HOSPITAL,
BARTON STREET EAST,
HAMILTON, ONTARIO.

ONTARIO SOCIETY FOR CRIPPLED CHILDREN

REQUIRES

GRADUATE NURSE

To assist with the supervision of their five summer camps. Administrative ability required — camping experience preferable but not essential. Salary commensurate with experience. Employee Benefits. Permanent Position.

Apply in writing to

MISS HELEN WALLACE, Reg'd. N.
SUPERVISOR OF CAMPS
ONTARIO SOCIETY FOR
CRIPPLED CHILDREN
92 COLLEGE STREET, TORONTO
ONTARIO

GRENFELL LABRADOR MEDICAL MISSION

Positions now available for General Duty Nurses in Grenfell Mission hospitals in northern Newfoundland and Labrador. Housekeeper for modern 120-bed hospital also needed.

For full information please write:

MISS DOROTHY A. PLANT, SECRETARY,
GRENFELL LABRADOR MEDICAL MISSION,
48 SPARKS ST., OTTAWA 4, ONTARIO.

CALIFORNIA

REGISTERED NURSES

(General Duty with opportunity for advancement)

New modern 130-bed General Hospital in dynamic college city in beautiful San Joaquin Valley only 2 hours from Los Angeles

Only evening & night positions open
Starting salary $350 per mo.
5-day, 40-hr. work wk. Progressive personnel policies.
Transportation cost to California will be reimbursed after 2-yr. satisfactory service.

Send full particulars immediately to:

DIRECTOR OF NURSING SERVICE, GREATER BAKERSFIELD MEMORIAL HOSPITAL
P.O. BOX 26, BAKERSFIELD, CALIFORNIA

SUPERINTENDENT OF NURSES

FOR

CLEARWATER LAKE HOSPITAL
THE PAS, MANITOBA

Required May, 1960. Well equipped 160-bed hospital with general and tuberculosis patients. Salary range $355-$400 per month, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies. For information and application apply:

Director of Nursing Services:

SANATORIUM BOARD OF MANITOBA,
668 BANNATYNE AVENUE, WINNIPEG, MANITOBA.

REGINA GENERAL HOSPITAL

REQUIRES

1. Clinical Supervisors in obstetrics, medicine and surgery.
2. Registered male Nurse for a program of training and supervising male nursing assistants.

Apply to:

ASSOCIATE DIRECTOR, NURSING SERVICE,
REGINA GENERAL HOSPITAL, REGINA, SASKATCHEWAN

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:

Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

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Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
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Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

ALMOST EVERY PART of Canada has been battered by strong winds, freezing rains, snow and cold for the past several months. Though winter is officially over, many souvenirs of the season will still remain for weeks. Soon, Easter finery in a week or two will herald the coming of spring, 1960.

A quick glance through the pages of this issue will reveal the way in which the coming of a spring has influenced the appearance of the *Journal*. When we were looking over one of last winter's issues as it came from the printers, we came upon facing pages, each with a caption at the top and half way down the left hand page a third short title. There they were — set in the blackest type imaginable! It was enough to depress the most optimistic of readers.

We started an immediate search for some more attractive type-faces to lighten that awful gloom. Our editorial staff favored open-face letters that are sometimes seen. Our printer pointed out that by the time about half of the copies were printed each month, the ink would have filled in the open spaces giving us as black captions as we have had. We have therefore chosen a variety of type-faces for our major articles. Some of the brush headings, as for instance the one at the top of this page, we are keeping. We hope you will like the new faces.

* * *

For many years it has been the custom in CNA activities to have the first vice-president of the association serve as the chairman of the Finance Committee. It is in the latter capacity that our guest editor, HELEN M. CARPENTER, speaks to the nurses of Canada.

On leave of absence from her teaching position in the School of Nursing, University of Toronto, Miss Carpenter returned to the life of a student last autumn when she received the first fellowship to be awarded by the Canadian Red Cross Society. She has been studying industriously to obtain her doctorate in education. Final examinations start in mid-May so she will have completed her work prior to the convention in Halifax.

* * *

Ever since one of the popular monthly magazines published an article on the use of operative procedures in Parkinson's disease, we have been anxious to bring you an authoritative statement on the various aspects of this condition. We have no doubt that you have been asked questions about this operation just as we have.

We are very pleased, therefore, that the information you will require to give logical answers to the relatives and friends of these is now available. Dr. DeJong is the coordinator of the Parkinson's Project at Queen Mary Veteran's Hospital, Montreal.

* * *

Over the years, we have had several reports of programs for nurses at the Christian Workers' Centre at Five Oaks, Ontario. JEAN MACGREGOR represented the *Journal* at the Centre's special nurses' weekend last autumn and has written a more detailed account of the pattern followed in planning for the various groups. Completely non-sectarian, there is an opportunity for peaceful thinking and fellowship in idyllic surroundings. Nurses in Ontario particularly may be interested to note the dates of the special weekends planned for 1960.

* * *

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Blocks of rooms have been reserved in the Nova Scotian and Lord Nelson Hotels. In addition, arrangements have been made for Sisters to be accommodated in Mount St. Vincent College and student nurses at St. Mary's University.

Other hotels, motels and tourist houses have been surveyed and details regarding the accommodation in these are available from National Office.

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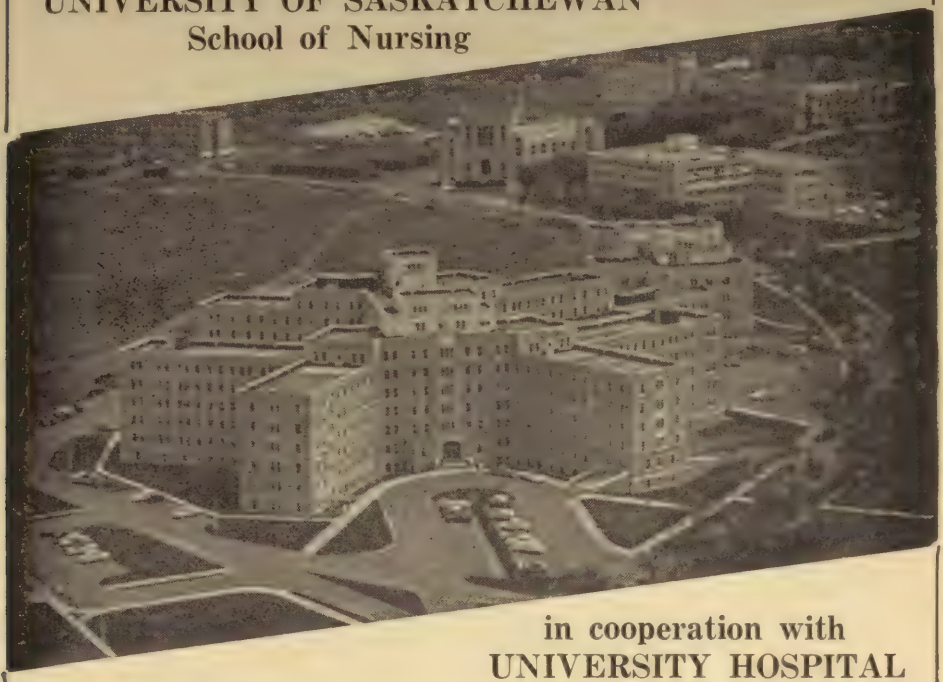
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Administration—Orally 5 to 15 mg. daily. For most indications one tablet three times daily.

Manufacturer—The British Drug Houses (Canada) Ltd., Toronto 14.

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Indications—In fear and anxiety where the comatic outlets appear as symptoms referable to the heart and gastrointestinal tract, e.g. in peptic ulcer and cardiovascular disorders.

Description—Each tablet contains 3 mg. 1-piperdine ethanol benzilate HCl.

Administration—One 3 or 4 times daily.

Manufacturer—Reed and Carnrick, Toronto 16.

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Random Comments

Dear Editor:

Many things remind of Australia and next year's ICN congress. The latest is a billboard advertisement of heaters in cars. It is called "a built in heater" — a kangaroo on skis with the baby in the pouch.

So how about letting us know, via the *Journal,* how much money we should save. Please don't wait until it is all gone on current conventions.

S. M., Ontario

¶*A schedule of return tourist fares supplied by Canadian Pacific Airlines Ltd. from different points in Canada appears below.* Ed.

Vancouver	—	$1,008
Calgary	—	1,062
Regina	—	1,106
Winnipeg	—	1,130
Toronto	—	1,216
Ottawa	—	1,248
Montreal	—	1,248
Saint John	—	1,305
Halifax	—	1,326
Chalottetown	—	1,350
St. John's	—	1,410

Dear Editor:

I just wanted to let you know how much I appreciated reading the article "Voice of the Past" in the December issue of *The Canadian Nurse.*

Sister Beatrice is known to me personally and at 85 years of age she is as interested in what is going on in nursing as she has always been. She never fails to ask what is new.

It is good for young nurses to learn a little about the struggle that took place to put nursing where it is now.

V. A., Ontario

Dear Editor:

While magnificent sunlight bathed my large silent house, Miss Percy's "Three Wishes" came to me like a good wine of friendship. At last, I said to myself, someone thinks as I do. She does not hesitate to wish for young nurses a hard life, to hope for it for them, so that the undeveloped potentials of their personalities may be drawn upon. She opposes conformity to the point of rebellion. Bravo! and I was really impressed by the quotation ". . . Do let the free part of your personality flap in the wind. Keep your sense of wonder fresh . . ."

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I am a pediatric nurse who spent over a year in postgraduate studies abroad. At present, I am a clinical instructor in pediatrics in a large Quebec hospital. I love students and I love children. I find my joy for life in them, and though I do not always have what I need in the way of materials and help, I give my all, in love.

And the third wish "joyish assishness," — it gets 100 per cent approval from me. I am not always serious about life. I joke, I laugh, I sing, so much so that I have been christened "the kid." I have interests outside my specialty, too. I give evening courses in home care to 40-50 men and women who are so anxious to learn. Some have little schooling, but I enjoy them so much and try to pass on to them a brightly lighted little flame that will help them, and that they in turn can transmit to others. They understand that with their hearts. I entertain friends in my home. Life has not been easy for them at times and I do not always know how to help. I just say nothing; but I am there and I love them.

Soon, I will be leaving for another tour of Europe. They know how to live better than we do, even if they do not have refrigerators or cars. "The essentials are always invisible to the eyes," St. Exupéry said.

To Miss Percy, thank you for what you have written. Miles separate us, but there is no doubt that the color of our inner lives has identical shades. With sincerity I extend my hand to you.

A. C., Quebec

Dear Editor:

Will you please advise me if it is possible to obtain reprints of the Table of Antidotes printed on page 1095 of the December 1959 issue of the Canadian Nurse. I am interested in obtaining a copy for our First Aid Room as well as copies for our First Aid classes.

L. M. H., British Columbia

¶*No reprints of this Table were ordered.* Ed.

Dear Editor:

I was interested by your article entitled "Going to Boston in February?" and hope to attend the American College of Surgeon's convention.

I find the *Canadian Nurse* very enjoyable as well as informative and anticipate the arrival of my magazine every month. It is well worth the price of the subscription.

S. J., Alberta

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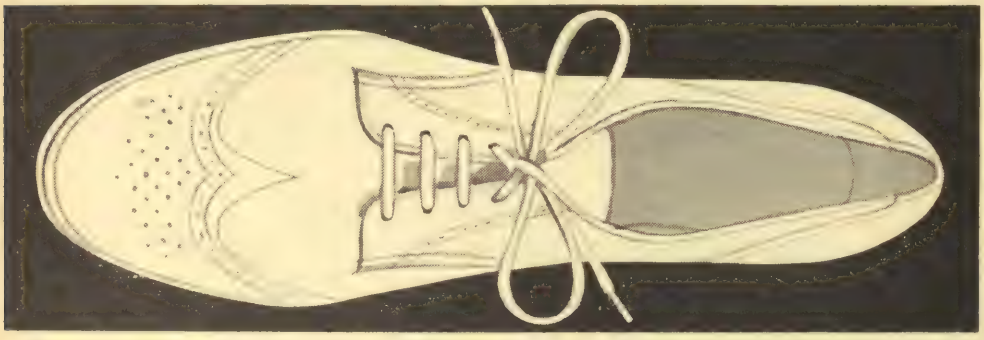
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 4

MONTREAL, APRIL 1960

THE CHALLENGE OF A NEW DECADE

NOW THAT APRIL IS HERE, there are but two months until nurses from all parts of Canada will be travelling to Halifax to attend the biennial meeting of the Canadian Nurses' Association. The purpose of this editorial is to acquaint you with one of the recommendations that will be presented at the meeting.

As you know, the affairs of the Association are financed by membership fees. Each provincial association forwards to the National Association two dollars annually for each member. During the past biennium, this money was divided among the following activities:

— 38¢ per member was passed on to the International Council of Nurses to pay the membership fee at the International level and to meet other international expenses.

— 58¢ per member was spent on activities associated with nursing service.

— 50¢ per member was spent on activities associated with nursing education.

— 22¢ per member was spent on public relations.

— 32¢ per member was spent on the Pilot Project for Evaluation of Schools of Nursing.



(Ballard & Jarrett)

HELEN M. CARPENTER

Due to limitations in the budget, the Association has had to curtail certain activities and delay launching new projects that many feel should be undertaken. The membership of our Association has increased 46 per cent in the last ten years. During this time the cost of goods and services in Canada has risen until now the purchasing power of each dollar is 20 per cent less than it was ten years ago. The Committee on Finance gave serious consideration to these problems, and recommended to the Executive Committee that the membership fee be increased to four dollars a year. The Executive approved this recommendation, and it will be presented to the biennial meeting for the decision of the voting delegates.

Why is additional income needed? How will the money be spent if this recommendation meets with the approval of the voting delegates?

1. The affiliation fee to the International Council of Nurses will probably be increased in 1961. Expenses at the international level are higher for the same reasons that they are higher at the national level.

2. Additional funds are needed for the on-going work of the Association. One of the recommendations of the Structure Study was that provision be made for the national committees to hold full meetings during each biennium. Prior to this time, important business was conducted by "core committees" consisting of members residing in one geographic area. Since the committees were reorganized, full meetings of both the Committee on Nursing Service and the Committee on Nursing Education have been held each biennium. It has not been possible to finance full meetings of the other national committees regularly. We would like to make provision for such meetings, and to be able to arrange additional meetings, conferences or workshops when these are needed to study important problems.

3. As a result of the growth of the work of the Association, we have had to rent more suitable office accommodation. If we had sufficient capital we could purchase or build a CNA House. As rent is high, it would be economical to invest capital in our own headquarters.

4. The Pilot Project on Evaluation of Schools of Nursing has been completed, and the report will be presented at Halifax in June. If we are to be in a position to study the findings and to implement the recommendations, we will need to budget for this purpose. We cannot make a fitting contribution to the improvement of nursing service and nursing education without such expenditures.

5. In view of the recent introduction of prepayment hospital care plans in many provinces, the Committee on Nursing Service feels it is urgent that we develop criteria for staffing patterns for hospital nursing service. Projects such as this fall into the category of research. An Association such as ours should be able to undertake studies of this kind, and assist in the development of research in nursing.

6. There are few nurses in Canada with suitable preparation for research. Funds should be available to assist interested nurses to secure preparation. At present the Association has a loan fund of approximately $9,000 from which nurses undertaking graduate work borrow amounts of $500 or less. With additional financial support we could increase the amount available to assist nurses interested in securing advanced preparation.

These are the reasons your Executive feels the CNA membership fee should be increased. Many will recall the theme of the fiftieth anniversary convention: "Into the Future Open a Better Way." This phrase was taken from an address of Mary Agnes Snively:

It is therefore, your privilege and, I may add, your duty, to be dedicated to the work thus far advanced, and into the future, open a better way.

To "open a better way" will require among other things, a financial structure in keeping with the demands that are being made upon us in this challenging stage in the development of nursing. In a period of unprecedented expansion and prosperity in our country, we believe nurses desire to accept the challenge. One way we can open a better way is through increased support of the work of our National Association.

HELEN M. CARPENTER, M.P.H.
First Vice President
Canadian Nurses' Association

Practical Problems of Parkinson's Disease

DAVID DEJONG, M.D., M.R.C.P., F.R.C.P.(C)

The shaking hand, the shuffling gait, the dejected expression and posture mark the sufferer of Parkinson's disease wherever we may meet him. Fortunately medical science can now offer him hope for a productive life in spite of his disability.

History

IT WAS IN 1817 that James Parkinson of London, England described the disease which he called "Shaking Palsy" but which today is more often called "Parkinson's disease," or the Latin equivalent of his own title, "Paralysis Agitans." The terms palsy and paralysis are not synonymous however, for palsy refers to weakness or partial paralysis, whereas paralysis more correctly means total incapacity or loss of function.

No one has yet offered a better term for this disease than "shaking palsy" because it is a good description of the obvious clinical aspects. The two main features of the disease as it strikes the patient are tremor or shaking of the limbs, head, jaw, lips, etc., and rigidity or stiffness of the muscles, which makes them somewhat weakened though not paralyzed. In Parkinson's time it was not fashionable, apparently, for doctors to lay hands on their patients, for Parkinson obviously never examined his patients as we do today. He merely observed them closely, and after observing six patients, wrote his famous paper. Because he only observed them he only noticed the shaking and did not realize that the palsy was due to rigidity of the muscles.

Tremor

The tremor of Parkinson's disease may come on suddenly and then pass off to recur at some later time, or it may develop gradually. It may affect any or all limbs, usually starting in the periphery: the hand or the foot. It tends to occur more at rest, to be worse when the patient is excited or emotionally upset, and to disappear when he uses the affected part. It also disappears while he is asleep, which is merciful, because it can be so severe during the day, in advanced cases, that all the limbs, body, and head shake so that one can hear the beds rattling down the halls. If they shook like this at night sleep would be impossible! Whatever happens to the disease in sleep we do not know, for when the patient sleeps so does his disease, so to speak.

It needs no emphasis that this tremor is incapacitating. The patients are not only socially embarrassed by it, but find it physically impossible to carry out many of the functions of daily living which require careful, coordinate movement of the limbs, such as drinking, eating, dressing, playing bridge, and so on. It is disturbing to other people and makes it hard for an afflicted person to keep or obtain a job.

Muscle Rigidity

The rigidity of muscles is rather different. It is not visible directly as tremor is, but can be more serious in its effects. When you bend the arm of a patient with rigidity it feels stiff, like bending a soft lead pipe. Sometimes, as you bend the arm it will give way suddenly in a series of little jerks because there is some underlying tremor showing through the rigidity ("cog wheel" rigidity). There is usually not much pain, or certainly not as much as there is with the stiffness of arthritic limbs where the patient will not let you move the arm because the muscles are in protective spasm due to pain, and the joints are swollen, tender, painful and deformed. These are two different forms of stiffness of muscles. The other common form of stiff muscles is that due to spasticity. Spasticity is the kind of stiffness one sees in hemiplegic patients, paralyzed down one half of the body after a stroke, for

Dr. DeJong is the coordinator of the Parkinson's Project at Queen Mary Veterans' Hospital, Montreal.

example. It differs from rigidity in that it does not give way in a series of jerks but only gives way at the end of the movement like the feeling imparted by replacing a blade in a pocket knife: the stiffness increases as the blade closes and then suddenly gives way as it falls in. Hence this is called "clasp-knife" rigidity. It also differs in being associated with overactive reflex jerks when they are tested with a neurological hammer.

We do not know exactly how much of the body muscle is affected by rigidity in Parkinson's disease. We think that most if not all of the muscles can be involved though the ones actually affected vary among different patients. This is why patients with this disease do not all appear the same though they are often described in the books as if they did. Furthermore, some patients will show mainly tremor, others will show principally rigidity, and most have some of both. But the more rigidity there is the less the tremor in any one affected part, because when rigidity develops it makes the muscles stiff and they cannot shake so easily.

What we have known for a long time about rigidity of muscles in Parkinson's disease is that stiff muscles are hard to use. Since the obvious parts of the body used by everyone are the face, hands, feet, legs and arms, these are where it has been most noticeable. Recently we have come to realize that the rigidity may have serious effects on the patient's voice, swallowing reflex, chest movements, bowel and bladder function, and even hearing. The rigidity of the face gives rise to a stiff immobile face that tends to look a little sad. The patient is unable to express joy even if he might be able to feel it despite the misery of his disease, because the stiff facial muscles can no longer relax into a smile. His neck becomes stiff and tends to droop forward, the back bends, and we get a picture of a stooped, unhappy person. The rigidity when it affects the shoulder muscles will not permit the arms to swing when he walks, nor if in the hips and thighs will it let the legs step out, so that he walks with small steps and can sometimes hardly get his feet off the ground — he shuffles along.

When many of the body muscles are stiffened up in this way the patient becomes more like the proverbial bean-pole than a nimble, spry man, and when he moves — and he may find it difficult to start moving because he is so stiff — he may find it hard to stop. He looks as if he is going to fall and seems to keep going because he feels he *will* fall if he stops. The chronic contraction of muscle may cause deformities of the hand and wrist like those seen in patients who have had a stroke. If the back muscles are stiff he may be unable to sit up in bed or in a chair because those muscles won't let him, and he slips down. As some patients say, they have "a board" in their back. A soft mattress makes it much more difficult for patients with stiff trunk muscles to turn so they should be given a hard mattress of the "orthopedic" type. Care should be taken to prevent bedsores due to inadequate turning in bed. The family or the patient himself may notice first a general slowing up without any obvious stiffness or tremor. All patients find they are much less stiff after being active, so activity should be encouraged.

Chewing, Talking or Swallowing

While all these effects are tragic in themselves it is more serious when the muscles concerned with the vital processes of life itself are affected. We have only begun to realize how important these are. If the tongue is stiff, and one can easily find out if it is by asking the patient to move it sideways, or in and out as fast as he can, then he will have trouble chewing, talking and swallowing. If the muscles that open the mouth are stiff, then the jaw will hang open and saliva will drip out on the pillow and on his clothes. The patient with this problem may actually have to wear an absorbent bib made of towelling, and may require a rubber pillow cover in bed. Some of this drooling may be helped with drugs, but it cannot be entirely controlled. Alternately, the jaw may be held closed so tightly that he is unable to take more than soft or liquid food, or to brush his teeth, or even allow the nurse to clean his mouth properly. Mouth cleanliness is very important to these patients, not only to prevent aspiration of infectious material but because it

makes tongue movements easier, improves taste, and imparts a feeling of well-being.

Respiratory Tract

Great difficulty occurs when the valve at the upper end of the esophagus stiffens and is difficult to open. In normal people, this valve opens automatically when one swallows, but in these patients food may not pass properly, and having no other place to go may tumble down the trachea into the lungs causing aspiration pneumonitis and even lung abscess, both of which can be fatal. When these factors are combined with stiffness of the muscles of the chest wall so that the lungs cannot move properly, the patient is unable to cough effectively and so cannot clear his lungs. This puts him in a dangerous condition, indeed! One can easily find out how difficult it is for the patient to perform these vital functions by giving him a glass of water to drink, then watch how fast he does it, and how long it takes for each swallow. If some water happens to get into the lungs it will not do as much harm as other liquids or food.

The lungs can be tested by simply asking the patient to cough as well as he can. The normal person when asked can produce a sharp, loud, effective cough, as sharp as the click of the tongue. The patient with Parkinsonism cannot do this. His cough is weak, grunting and rather pitiful. One can hear this kind of cough in very many old people on the wards, weakly stuttering a feeble cough that is almost like a gentle cry. This not only indicates weakened respiratory muscles, but means that they cannot clear their lungs properly. Any matter in the lungs that is dangerous to health will not be properly removed. Great care must be taken with these patients to help them overcome this serious disability. Physiotherapy can be most helpful in teaching them how to make the best use of their lungs in order to keep them clear, (as well as helping to relieve the stiffness of other muscles). They should never be given anything to eat or drink when in the lying position because they are then much more likely to have the food enter the lungs. While it seems kind to offer the patient a drink out of one of those little teapot cups with a spout on the side, it can be dangerous. Patients should always be propped up to eat or drink; otherwise there is a greater risk of lung complications.

Very occasionally the larynx may tighten up, due to stiffness of the muscles in this region. When that happens the anesthetists may have to be called in a hurry to pass an endotracheal tube. Even a tracheotomy may be necessary, though these occasions are rare.

Dietary Problems

Because of all the shaking that the patient does he may perspire profusely and use up considerable energy — so much so that if he burns up more energy than he takes in as food he may lose weight. This is particularly true if it is difficult for him to eat. He probably doesn't take all of the water that he needs because he cannot hold a glass, so straws should be provided, and special self-help jugs and tumblers, such as arthritics use. Even then he may not take enough to eat or drink. He will avoid foods that are hard to chew and swallow, such as fruits and vegetables. These, of course, are necessary for normal bowel action.

Constipation

Taken all in all, with the lack of enough water, the lack of exercise due to the stiffness confining them to bed or chair, the lack of bulk foods in the diet, and the prolonged use of atropine-like drugs, it is not surprising that constipation is so common among these patients. We do not know how much of the constipation is due to the effect of the disease on the bowel itself, if any, but it certainly seems that the patient is unable to defecate normally because this act requires the coordinate use of the abdominal muscles with those of the pelvic floor. These muscles, too, are probably affected. Constipation becomes a very wearisome problem. Dealing with it requires that patients be encouraged to drink more water, take the trouble to eat bulkier foods, and laxative foods such as figs, prunes, etc., get more exercise, and practise regular bowel attention. Even then, however, enemas are often necessary. Impaction can lead if ignored, to bowel obstruction, and

even gangrene of the bowel requiring surgery for its relief. The rectal administration of glycerin suppositories may suffice when simple lubrication is enough, but when more active help is required "Dulcolax" suppositories often induce bowel action, though two suppositories inserted at one time may be necessary in severe cases. With practice and proper timing these can help keep the patient out of more serious bowel trouble. If not, regular enemas are necessary.

The Bladder

Similarly, the bladder may be affected by rigidity. When this happens it is unable to empty itself effectively, and some urine always remains after each voiding. This makes the bladder more prone to infection for it normally relies on regular "flushing" to carry away any bacteria. When residual urine remains, infection accumulates and may reach the kidneys causing renal failure with or without hypertension, and death. When the bladder loses its ability to contract properly the patient may have urinary frequency until the bladder becomes so large with overdistention that it overflows with dribbling incontinence. Alternatively, infection may render the bladder so irritable that it empties itself too often getting the patient up day and night, or if he is unable to get up, leading to incontinence and soiling. At this stage it is usually necessary to keep a urinal constantly available, and indwelling catheters may be inserted. These are bad for the patient, though convenient for the staff, because they may lead to urinary infection and only make matters worse. The problem remains difficult no matter what one does. Drinking more water helps dilute infective material, and so prevents it from accumulating. Sometimes operation helps the bladder function, but drugs only help for a time. Sooner or later infection takes hold.

Mental State

Mentally, these patients become very depressed — which seems hardly surprising. We believe that the depression is not only a reaction to the disease but for some reason occurs due to the disease process itself. Some become very suspicious and paranoid; others become mentally deranged and have to be placed in mental hospitals.

We are not yet sure how common this disease is but we think it occurs in one to two per cent of the population as a whole, more commonly in older people. Because this is such a serious disease, more and more attention is being given to it. Many different attempts have been made to treat it surgically. The latest and most successful of these operations involves making a destructive lesion in either the *globus pallidus,* one of a pair of large nucleii or collections of nerve cells in the brain below the ventricles on each side, or in the thalamus, a large central nucleus concerned with transmitting the messages of many brain circuits. It is not known how these operations help. Dr. Irving Cooper in New York discovered accidentally that, having tied off the anterior cerebral artery of the brain to stop the leak in an aneurysm suffered by a patient who had Parkinson's disease as well, the patient's tremor on the opposite side was arrested. The reason established for this was that the ligation of the artery caused an infarct of the *globus pallidus* which it supplied.

Surgical Intervention

While routine treatment of Parkinson's disease by anterior cerebral artery ligation had to be given up because it had other undesirable effects and dangers, it was felt worthwhile to attempt to make the lesion in the *globus pallidus* by other means. While it is done in different ways in different centres, basically the procedure involves inserting a long hollow needle into the brain through a hole in the top of the skull. Then, either a small amount of concentrated alcohol is injected ("chemo-pallidectomy") or brain tissue is cut by twisting a small loop of fine wire at the end of the needle. Done to the *globus pallidus* the operation is called "pallidotomy" when the cutting procedure is used, and to the thalamus it is called "thalamotomy." In either case the procedure is done with the patient fully conscious, using only a local anesthetic to make the burr-hole. This way the patient himself can tell when the lesion is in the right place because the tremor and/or stiffness disappears, which it

should do in a few minutes. Very often the needle and instrument are left in and the patient taken back to the ward so that additional small lesions can be made in the same vicinity if required when the result has not been completely successful at the first attempt.

Very few of the ordinary postoperative complications arise, because the patient remains awake. However, the lesion is made near many vital areas of the brain and the surgeon has to be careful to avoid them. If he damages the pathway for the eye then vision may be impaired; if the internal capsule — the bundle or sheaf of motor nerves coming down from the cortex of the brain to the limbs — is affected, then hemiplegia may occur just as when this same area is damaged by a stroke. Hemiplegia does occur in 3-5 per cent of operated patients. If the temperature-regulating centre is affected — and it is very close — then the patient may run a high fever. Older people, who are of course not as good risks, may be very drowsy for days or weeks after the operation. One therefore tries to avoid operating on these patients.

Despite the risks of operation — and they exist for surgery of any part of the body — the results can be most gratifying. Tremor may disappear, people return to work, social life becomes more pleasant. While improvement only occurs on the side of the body opposite to the brain lesion, the disease is usually worse on one side. Where it is bilateral two operations may be required on opposite sides, usually at an interval of some months. Improvement occurs in tremor in about 80 per cent of operated patients, and in rigidity in about 60 per cent.

Obviously it is desirable to operate on patients who are not too far advanced yet are severely enough affected to justify the risk. More and more centres in Canada are providing this surgery but it is important that the patient have an accurate diagnosis made before considering operation since not all forms of tremor are due to Parkinson's disease. Conversely, there are other rare neuromuscular diseases that are helped by the operation, though again we do not know why. Once the diagnosis is established it is necessary that the patient be fully investigated for any medical disturbances that need correction in order to ensure the least risk and the smoothest course.

Conclusions

Finally, for those patients who do not want the operation, are not ready for it, or cannot be offered it, there is still much that can be done. If the patient, family, physician, and hospital cooperate to provide a feeling of interest and care they, with the help of drugs like Artane, atropine, Kemadrin, Pagitane, Disipal, etc., which lessen rigidity and tremor, can make the patients more comfortable. Even surgery, of course, is not a cure. One of the striking things about modern medicine and nursing has been its cheerful focus on many of the so-called "incurable" diseases, thus bringing hope to the sufferer, encouragement to the family, interest to the physician, facilities to the hospital, and much-needed funds for research into their causes. Pafkinson's disease — the "shaking palsy" — is one of these.

The National Cancer Institute of Canada and its affiliate, the Canadian Cancer Society are responsible for most of the advances in cancer research in Canada.

One of the most recent advances is the securing of vital new information regarding the relation of viruses to cancer in experimental animals. A group of researchers at the Ontario Cancer Institute have succeeded in causing kidney cancer in new-born hamsters within 10 days after the injection of the polyoma virus. By means of an electron microscope they have studied the day-by-day development of these tumors and identified the viruses in the cells. The next step is to check human tumors for indications of virus beginnings. If a virus is involved, the possibility of controlling cancer is greatly improved.

"Fight cancer with a check-up and a cheque."

* * *

There are books of which the backs and covers are by far the best parts. — DICKENS

RESEARCH

Evaluating an Occupational Health Nursing Program by a Work Sampling Study

ETHEL M. GORDON *and* VERNA M. HUFFMAN

This article is condensed from the detailed survey report which is available on request from the Civil Service Health Division, Department of National Health and Welfare, Ottawa.

EARLY IN 1959 the nursing counsellor service of the Civil Service Health Division of the Department of National Health and Welfare was evaluated by means of a work sampling study. The study was carried out by the Civil Service Health Division with assistance from the Research and Statistics Division of the Department of National Health and Welfare.

The planning committee consisted of the chief supervisor of nursing counsellors, a research officer, a research assistant and a survey director. The survey director was a senior nursing counsellor assigned to the project on a full-time basis.

The nursing counsellor service was set up in 1947 as an integral part of the occupational health program being established for federal civil servants. A detailed account of the nursing counsellors' work and its relation to the divisional program as a whole may be found in an earlier number of *The Canadian Nurse*. In brief, it may be stated that services are provided by a Medical Centre in Ottawa and a network of health units strategically located in the Ottawa area. The health units are staffed by nursing counsellors whose work is closely allied to that carried on at the Medical Centre. A health unit is a self-contained establishment set up in a government building and directed from the Medical Centre. It consists essentially of a waiting room, treatment room, nursing counsellor office or offices, quiet or rest rooms, and storage space. The term "nursing counsellor" is used to emphasize the health counselling and teaching function of the professional nurse in the government setting. Care is taken to select nurses who show aptitude for interviewing and counselling. The public health nursing certificate is now a basic requirement. Of the 46 nursing counsellors employed at the time of the study, 32 possessed this qualification. Supervisory experience is required for nurses in the senior grades.

Briefly, the objectives of the nursing counsellor service may be stated as follows:

1. To provide essential first aid services for employees at their work.
2. To assist in keeping absenteeism within reasonable limits.
3. To do case-finding and to make referrals to appropriate sources in the community.
4. To assist the individual employee to help himself, through a program of health teaching and counselling.
5. To assist departmental personnel on matters affecting the health and welfare of employee groups.

After 12 years of experience it seem-

Miss Gordon is Chief Supervisor of Nursing Counsellors, Civil Service Health Division, Ottawa. Miss Huffman, who acted as survey director, is now on an assignment with the World Health Organization with her headquarters in Trinidad.

"Nursing Counsellors of the Federal Employee Health Service," *The Canadian Nurse*, February, 1957.

ed appropriate to determine to what extent these objectives have been realized and incorporated in the day to day practice of the health units. The study was designed specifically to evaluate each of these aspects of the nursing counsellor's function.

Purpose

The study was planned to obtain information about the activities of the nursing counsellors with the following questions in mind:

1. After 12 years, comprising initial planning, expansion and consolidation, is nursing time being used effectively?
2. Have some procedures outlived their usefulness?
3. Should new procedures or approaches be adopted?
4. Would a "fresh look" give insight into improved ways to plan work loads?

Although it was not intended to measure the quality of these activities it was anticipated that the study might help in future planning and in improving quality where the need was indicated.

Plan and Methodology

It was not considered practical to introduce observers into this work sampling study, as much of the work accomplished depends on the rapport establish between the nursing counsellor and the employee in the interview setting.

The working plan adopted, therefore, was to collect information from the nursing counsellors on their work activities following a statistically sound sampling schedule. The nurse was required to maintain a timed summary record of each successive activity during an observation period. To ensure that the whole nursing counsellor service was proportionately represented, the activities of each nursing counsellor were observed and recorded for each half-hour period of the day, according to a prearranged schedule — there being no duplication of observation periods. Furthermore, the schedule provided for an equal number of observation periods each day of the study.

The length of an observation period was set at one-half hour, making 15 half-hour periods in a 7½ hour work day. Each nursing counsellor had 15 observation periods representing every half hour of a day. Due to illness and other reasons, only 41 of the 46 nurses participated in the project.

Definition Sheet and Activity Record

To examine the scope of activity in health units two senior nursing counsellors recorded their activities for a period of one day. Using these records and activity classifications from other studies as a guide the committee drew up a classification of nursing counsellor functions. A definition sheet was prepared outlining the range of activities to be included under each function.

The definition sheet[1] was finally reviewed by the senior nursing counsellor group who found it a satisfactory framework for describing nursing counsellor activities.

A simple activity record was drawn up. It consisted of a single sheet of paper bearing the name of the nursing counsellor, her health unit number, and the date of observation.

Two columns on the left were used by the research team for coding, a third column was used by the nursing counsellor to record the time, and a fourth broad column was used by the nursing counsellor to describe each activity. A separate activity record was used for each observation period.

Orientation Program

The success of the project was dependent to a large extent on the cooperation of the participants. With this in mind, efforts were made early in the planning to acquaint the nursing counsellors with the objectives of the study through their regular staff education periods. A definite orientation program was arranged to discuss the method and the form to be used.

Key members of the planning committee met with the participants in group sessions. They were given a review of the objectives of the study and an outline of the method to be used. Through the use of the definition sheet and sample activity records the nurses were shown how to record their activities. They were instructed to describe their activities so as to

1. See Appendix

account for the full half-hour of the observation period, noting the time each activity commenced. Emphasis was placed on the fact that the study was to be made of the *functions* of the nurse, not of the individual nurse. It was explained that the data would be coded and subsequently statistically analyzed to study the nursing counsellor activities in relation to the various factors connected with her work. It was also explained that though the nurse's name appeared on the activity record a number had been assigned to each staff member. Anonymity would be preserved by using these numbers in the analysis data.

In the week preceding the study the nurses were asked to observe their activities for several half-hour periods and record them on the activity records just for practice.

The success of the orientation program was reflected in the attitude of the nurses to the project and by the quality of their participation. They were enthusiastic throughout the study and their recording, in general, was of high standard.

Tabulation of Data

For the actual observation periods the nurses were notified immediately before they were to participate.

The completed activity records were collected daily and brought to the survey director for coding. The regular collection of records made it possible to check the observations for detail as soon as possible after the observation period so that inaccurate or inadequate recording could be checked with the individual nurse while the activities were still fresh in her mind.

The research assistant checked the coding on each record and together with the survey director tabulated the time spent on activities classified according to the definition sheet.

From the tabulation sheets, tables and charts were prepared with the assistance of the Research and Statistics

CHART 1 Percent Distribution of Time Spent According to the Type of Activity by all Nursing Counsellors



Division of the Department of National Health and Welfare.

Presentation of the Findings

For presentation of the findings, the nurse counsellors were brought together in two groups — half of the staff in the morning, the remainder in the afternoon of the same day. The objectives of the study and the methodology were reviewed. Each nurse was quietly handed a slip of paper on which was the number by which her activities during the project were shown on the tables and charts. When the findings had been presented by the survey director and the research assistant, the nurses were given time to examine the tables and charts to locate their numbers. Interested discussion took place — particularly in small groups during the coffee break. The nurses were told that a "profile" (similar to the overall "profile" in Chart 1), had been prepared for each unit. Considerable interest was expressed in these unit "profiles," and it is planned to give the staff of each health unit an opportunity to examine them at a later date.

"Standards" Used

Previous studies did not provide an appropriate standard against which to measure the results of this study. The following steps were taken to set up a unit of measurement. From Chart 1, "Percent Distribution of Time Spent according to Type of Activity by all Nursing Counsellors" the eight main activities were consolidated into five major functions as shown in Chart 2, "Time of Day Distribution of Major Functions for all Health Units." Of the remaining six activities on Chart 1, "Education" was kept as a separate function while the other five activities were classified as "Miscellaneous." This consolidation gave seven functions for which to set up a standard.

The senior nursing counsellors were asked to consider the seven functions and, as a group, to estimate what percentage of all nursing counsellor time should be spent on each function. This action was taken after the study had been completed but before the results were shown. In this way, the senior nursing counsellors arrived at their time distribution standard independent of the data of the study.

CHART 2 Time of Day Distribution of Major Functions for all Health Units

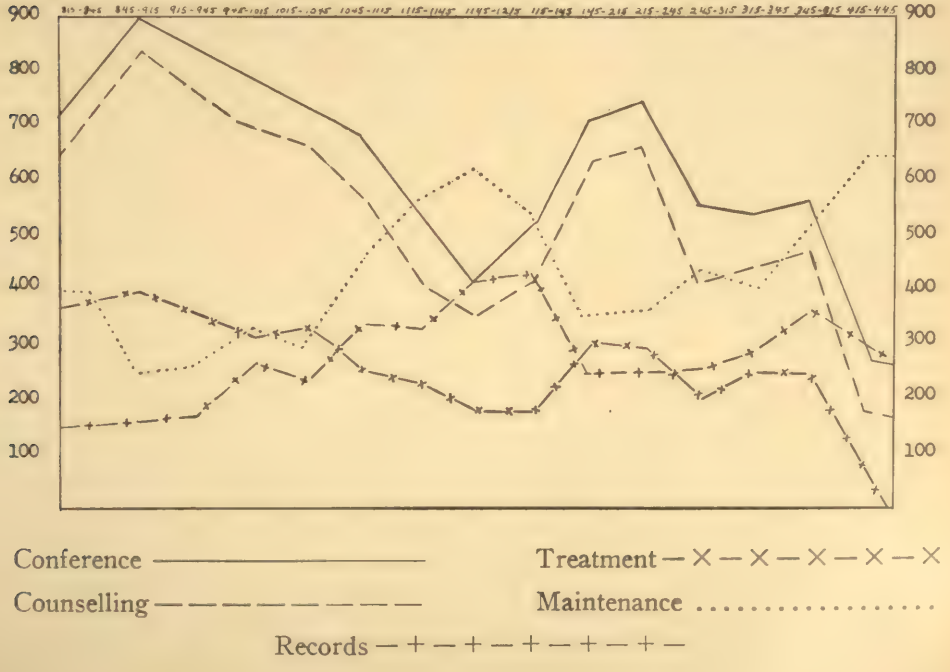


TABLE 1. Percent Distribution of Time Spent on Major Functions[1] by Individual Nursing Counsellors, by all Nursing Counsellors, Compared with Standard[2] Prepared by Senior Nursing Counsellors.

Standards		Individual Nurses																					All Nurses	
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21		
Counselling ($Cs + D_1$)	33%	17	23	23	11	20	10	17	25	29	15	11	28	22	25	20	15	32	19	15	13	23	Counselling ($Cs + D_1$) (14 + 8) =	22%
Conference ($Cf + D_2$)	17%	10	4	8	12	26	4	7	8	11	2	3	21	5	3	14	6	12	8	12	2	6	Conference ($Cf + D_2$) (5 + 3)	8%
Treatment	17%	12	11	16	8	14	29	15	10	23	33	32	13	23	13	28	22	21	23	24	38	24	Treatment	22%
Records (R + MC)	15%	29	31	28	43	26	38	41	39	15	24	30	25	29	33	14	16	18	26	29	24	38	Records (R + MC)	26%
Maintenance	10%	11	12	15	8	7	6	11	5	18	20	18	2	8	14	7	18	3	9	9	19	2	Maintenance	11%
Education	5%	8	8	1	—	2	7	2	—	—	2	0	4	5	8	7	5	4	5	1	2	—	Education	3%
Miscellaneous	3%	13	11	9	18	5	6	7	13	4	4	6	7	8	4	10	18	10	7	10	2	7	Miscellaneous	8%

Standards		Individual Nurses																					All Nurses	
		22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41			
Counselling ($Cs + D_1$)	33%	30	23	6	24	21	41	16	29	19	29	51	20	34	18	24	33	22	24	25	25		Counselling ($Cs + D_1$) (14 + 8) =	22%
Conference ($Cf + D_2$)	17%	3	10	8	4	4	11	—	14	3	6	7	5	11	2	5	6	7	7	9	1		Conference ($Cf + D_2$) (5 + 3)	8%
Treatment	17%	40	20	31	30	34	19	39	21	17	23	8	14	19	30	26	17	19	40	21	23		Treatment	22%
Records (R + MC)	15%	12	20	21	20	29	9	23	24	35	12	23	33	15	33	27	19	37	4	23	25		Records (R + MC)	26%
Maintenance	10%	10	18	17	13	8	10	20	4	16	18	3	19	9	6	10	18	8	17	9	15		Maintenance	11%
Education	5%	—	—	6	4	—	—	—	1	1	7	2	7	0	7	3	—	—	3	—	9		Education	3%
Miscellaneous	3%	5	9	11	5	4	10	2	7	9	5	6	2	12	4	5	7	7	5	13	2		Miscellaneous	8%

[1]Broader grouping of activity categories reported in Table 2.

[2]These standards were prepared in conjunction with the study independent of the data presented in this table.

Use of the Standards

1. Table 1 presents the *"Percent Distribution of Time Spent on Major Functions by Individual Nursing Counsellors, compared with the Standard Prepared by Senior Nursing Counsellors."* It would indicate that the standards in major functions are being met by a few nursing counsellors.

(i) *Counselling*
3 nurses met the standard
2 nurses exceeded the standard
36 nurses were below

(ii) *Conference*
none of the nurses met the standard
1 nurse exceeded it
40 nurses were well below

(iii) *Treatment*
2 nurses met the standard
28 nurses exceeded it
11 nurses were below

(iv) *Records*
4 nurses met the standard
33 nurses exceeded it
4 nurses were below

(v) *Maintenance*
3 nurses met the standard
27 nurses exceeded it (10 of these by only 2%)
11 nurses were below

While we may discount some individual differences due to sampling variations the picture remains clear that, in general, the nursing counsellors fell below the standards for "Counselling" and "Conference," and exceeded the standard in time spent on "Records." For "Treatment" and "Maintenance" there was a tendency for the group as a whole to exceed the standard.

Summary of Impressions

Space allows us to present only a few of the charts and tables prepared from our study. As noted, the final and detailed report is available on request.

Although a high degree of objectivity is necessary in conducting a study of this nature, certain impressions emerge which deserve special mention.

The voluntary interview would appear to be an area in which the service might expand its activities to move towards the standards set. Since the afternoon period shows a much smaller proportion of time spent on interviews, it is here that efforts might usefully be directed towards increasing employee participation in the counselling service.

The fact that senior nursing counsellors more nearly met the standard on time spent on "Conference" seems to indicate a need to look into the amount and quality of leadership the nursing counsellors in the smaller units are receiving — particularly in the areas of case follow-up, departmental relations and the use of community resources.

Several of the nursing counsellors have already offered suggestions, on the basis of the findings, for improving the quality of service and for economizing on nursing time. They have expressed concern over the high percentage of time spent on "Records" and the lower percentage on "Counselling." It is planned to make direct reference to the study during staff education periods in the coming year. In this way it is hoped that the nursing counsellors themselves will have a major role in interpreting and acting upon the findings of their study.

As mentioned earlier, one senior nursing counsellor was assigned full-time to the study; others were actively involved with research personnel in an advisory and consultant capacity. This method proved entirely workable in the program studied. It had the added advantage of causing a strong nucleus of nursing counsellor staff to feel a personal responsibility for the study and its long range value to the program.

The planning and conduct of this work sampling study has been a stimulating experience. The initial presentation of findings to the participants and to the medical staff of the Civil Service Health Division has met with interest and enthusiasm. With the present study as background, it is felt that a second study, carried out in about five years would enhance the value of this initial research venture.

Appendix

Definition Sheet for Work Sampling Study of Nursing Counsellor Activities, 1959.

The activities of the health unit have been divided into the following categories to serve as a guide in completing the "Activity Record."

Treatment (T) — this includes carrying out nursing procedures and examinations of employees; also health

teaching specific to the treatment, *i.e.* explanation and demonstration of medication and treatment, (*e.g.* dressing with instruction for home care).

Counselling (Cs) — this includes health teaching in its broader sense (as compared with treatment) *e.g.* interview on nutrition in reference to anemia, obesity or malnutrition; consideration of all other employee problems.

The actual mechanics of counselling are familiar to nursing counsellors and include listening, observing, evaluating, etc.

Records (R) — this includes: Employee health records, tally sheets, monthly summaries, separation lists, filing of records, unit history, rough notes, memos, draft copies, etc.

Medical Certificates (Mc) — this heading has been included to determine the time required for transfer of information directly from medical certificates to employee health records and indirectly by telephone from unit to unit.

Conference (Cf) — a formal exchange of views concerning a specific problem or topic. It is important to indicate *with whom and where* you have the conference, *e.g.* conference with nursing counsellors in your own or another Health Unit; conference with Medical Centre consultant; conference with other community agencies; conference with director, personnel staff or supervisor of departments served.

Discussion (D1 - with employees; D2 - with staff) — informal exchange or information.

Appointment (A) — making an appointment (*e.g.* Medical Centre or community agency) which does not include discussion or conference.

Education (E) — this includes activities which increase knowledge and skill of staff, such as reading periodicals, staff education meetings, educational films, orientation of new nurses, inservice development of staff, evaluation.

Maintenance (M) — this includes maintenance of Health Unit — setting up treatment room, quiet room, care of equipment and supplies, trays, etc.; requisitioning of supplies including literature.

Personal (P) — engaged in one's own activities; *e.g.* telephone call re own dental appointment.

Looking for (L) — when a real *search* is needed to locate records, keys, information, people, etc.

Transit (Tr) — this includes duty time spent in going to conference outside Health Unit or to relieve in another Health Unit or to another part of the building.

Free Time (xx) — any time not spent on above activities.

Identical Form, Inc. has prepared three aids for use in the rehabilitation of mastectomy patients.

A teaching kit for classroom demonstration

The kit contains a folder with illustrated teaching aids and a professional sample of the Identical Form. Because of the expense involved in assembling this material, only one kit is available, without charge, to each accredited school of nursing upon receipt of an official request signed by the director of nursing.

A guide for the mastectomy patient

This pamphlet assists nurses in counseling patients and demonstrating the prescribed exercises. It gives each patient the comfort of tangible reassurance. Written by a woman who has had a mastectomy, patients will find it sympathetic, understanding and optimistic. The guide illustrates ten basic postoperative exercises for individual selection. It encourages interest in good grooming, hobbies and sports. The importance of the doctor-patient relationship is carefully respected. There is no reference to cancer, malignancy or the Identical Form.

A brochure, "The Total Care of Your Mastectomy Patient"

This is an abridgment of the recent text, "Breast Cancer, Its Diagnosis and Treatment," by Edward F. Lewison, M.D., of the faculty of medicine of Johns Hopkins University. It lends itself to classroom teaching because it clearly outlines the pertinent role of the nurse in the postoperative care of the mastectomy patient.

For copies of these aids write to: Identical Form, Inc., 17 West 60th Street, New York 23.

No one can build his security upon the nobleness of another person.—Willa Cather

RHEUMATOID ARTHRITIS

W. G. MacDougall, M.D., M.R.C.P.E.

In spite of major discoveries in the medical field and the ever-increasing list of "miracle" drugs, some disease conditions still resist efforts to solve the mysteries of their etiology and control. Rheumatoid arthritis belongs in this category.

Rheumatoid arthritis remains one of the great scourges of the human race. Like leukemia, its course has defied understanding in spite of the expenditure of much money and the constant probings of many research workers in centres throughout the world. Unlike leukemia, the disease does not kill. It inflicts a vast amount of suffering, not only upon the victim but indirectly on his immediate family as well. Although it attacks all age groups, persons 30-50 years of age, when earning capacity and family responsibilities are at their maximum, are more frequently affected. In many cases progressive crippling and permanent incapacity results. This prevents the mother from caring for her family or the father from earning his living. The cost of prolonged illness and the loss of earning cacapity often result in serious economic hardship for the whole family. Consequently, the disease has important social implications. For this reason, among others, national and international organizations have grown up whose aims are to foster interest, to stimulate research and to exchange knowledge concerning this disease and related rheumatic conditions. Special research centres have been established in some universities.

While the course of the disease eludes us, a great deal of knowledge has accumulated, especially in the last 15 years. The fundamental lesion appears to be located in the collagen fibre of the connective tissue. This fibre loses its characteristic structure and is replaced by a disorganized amorphous material. The process is described as "fibrinoid degeneration" — the amorphous material resembles fibrin but has not been proven to be fibrin. This change is accompanied by varying degrees of inflammation and the combined effects of the two processes provide the remarkable varied clinical manifestations of rheumatoid arthritis. Specific injury to the collagen fibre is not peculiar to rheumatoid arthritis. It occurs in other dissimilar but closely related diseases — notably rheumatic fever. All such diseases have been grouped together and called by Klempener "the collagen diseases." This has distinct weight in focusing attention upon collagen and other fibres which together with the ground substance form the connective tissue. Much of today's research into rheumatic disease is concerned with identifying and understanding the finer structure and function of connective tissue. We now know that far from being merely a mechanical supporter of the more specialized cells and organs of the body, connective tissue is vitally concerned with repair processes, antibody formation and the storage and exchange of nutrients, salts and water.

Inflammation is the response of the tissue to injury or threat of injury and is directed towards healing and the removal of the injurious agent. This accomplished, the inflammatory process resolves. In rheumatoid arthritis, no invading agent has been identified and the inflammatory response is haphazard and uncontrolled. The body behaves as though its internal intelligence system had gone wrong and it was endeavoring to combat a nonexistent invasion — the excessive reaction finally causing irreversible damage. In this sense it resembles leukemia in which there is uncontrolled reproduction of cells in response to some unidentified stimulus. In both cases the normal homeostasis over tissue responses has broken down.

Another important fact that has emerged is that in a high proportion of cases an abnormal antibody is present in the plasma. This can be identi-

Dr. MacDougall is a physician at Regina General Hospital, Regina, Sask.

fied by special techniques and forms the basis for certain agglutination tests such as the Rose-Woaler Test and the Latex Fixation Test — sometimes used in differentiating rheumatoid arthritis from other members of the collagen diseases. The antibody is often referred to as "rheumatoid factor."

A remarkable feature of the disease is the great variation in tempo of the inflammatory process. Sometimes it begins suddenly, progresses rapidly and in the course of a few months the affected joints are permanently destroyed and fixed. In other cases the disease is mildly but continuously active for many years causing only trivial disturbance of function. Different degrees of activity often coexist in one patient. The inflammatory process may cease for varying periods or permanently. Should this occur before joint cartilage has been destroyed function may be returned to normal. There is good evidence that perhaps half of the cases undergo complete remission in this way. Although we sometimes refer to "burnt-out" cases of rheumatoid arthritis, the disease in fact does not run a predictable course. It is very difficult to express a prognostic opinion in any given case. For the same reason the appraisal of the efficiency of specific drugs or other therapeutic measures is uncertain. Many different drugs are used in attempts to control the activity of the disease. At present there is no general agreement as to which drug is most effective.

Few other diseases provide such a challenge to doctor, nurse and physiotherapist as the management of a case of rheumatoid arthritis. In the absence of specific drug therapy, the main function of the medical team is to maintain morale and to encourage the patient's active participation in his own treatment in the hope that the disease will eventually become inactive. Crippling results from muscle disuse and misuse, as much as from direct joint injury. Much crippling may be prevented by active muscle exercise. *This is the most important single measure available to us.*

Many patients show a striking apathy and indifference towards their disability. Active muscle exercise can be performed only by the patient himself. To overcome his apathy and maintain his interest requires constant supervision and encouragement. Most other forms of therapy are merely aids towards realizing this objective: aspirin and codeine to relieve pain; heat and massage to remove muscle spasm; splints to maintain correct posture. With controlled rest, exercise and analgesics, quite remarkable increases in activity and physical well-being can be achieved.

There is evidence that some drugs such as gold salts and chloroquine can induce a remission but for reasons already discussed it is difficult to assess their value in individual cases. A large-scale controlled investigation of this problem is at present under way. A definite answer concerning the value of drugs should be available soon.

Cortisone (and related steroids) suppresses much of the inflammatory reaction accompanying the injury to collagen fibre and will produce quite dramatic symptomatic relief. This relief, however, can only be maintained by continuous use of cortisone and often in increasing doses. Cortisone itself induces changes in the tissues. The dosage and direction of treatment are fairly critical and, if exceeded, the resulting obesity and bone atrophy may be more crippling than the disease itself. Attempts to withdraw cortisone at this stage invariably make the symptoms worse. While cortisone has a definite though strictly limited place in managing rheumatoid arthritis, its use is a matter for expert judgment.

Until the cause of the disease has been uncovered, the relief of pain by drugs and the maintenance of function by active exercise must remain the major weapons against this distressing condition.

The Alumnae Association of the School of Hygiene, University of Montreal will hold its annual banquet on April 20 in the students' residence, 2222 Maplewood Ave. A special invitation is extended to graduates of 25 years or more. Please call Madeleine Gérard, at CR. 9-1906, or write 88 Duchastel St., Outremont, P.Q.

Rheumatoid Arthritis and You

VERONICA ORTON-JOHNSON

For the nurse who would like to exercise a greater degree of creativity in her work, the care of the patient with rheumatoid arthritis offers scope for initiative and ingenuity.

CAN YOU USE INGENUITY? Have you ever wished to be in a position where your ingenuity was really worthwhile? You may have the opportunity *shortly*. The nursing care of Mr. and Mrs. Rheumatoid Arthritis can offer you the chance! Will you fill the bill?

Place your warmth and interest in patients' problems, and your capacity to team up with others in readiness, for the successful nursing care of a sick, discouraged and apprehensive patient with rheumatoid arthritis will call on this, and all of your resources. Because of the character of the disease you will have no "specific" on which you may rely. Successful treatment can be carried out but *only* through cooperative effort by the patient, his family, his physician, the nurse, the social worker and the physical and occupational therapist.

The bill is a large one, but you can fill it if you are determined, if you have ingenuity and if you can keep in mind that your patient is an individual. Your first efforts might be a comprehensive plan that you have worked out with the other members of the health team mentioned above, plus the patient and his family. Your first consideration then could be "what progress has this disease made with my patient?" Provisionally we might consider the early rheumatoid patient, in whom the disease is relatively mild, as one with the first or acute stage of rheumatoid arthritis. The disease would involve only a few joints. The joints may be painful and swollen, the body temperature elevated and the patient toxic to some degree.

Or does your patient belong with phase two, where rheumatoid arthritis has been present in the patient for some time? Pain has discouraged and frightened him from activity. He desires relief and rest. He looks, and sees his future as a glum one, and he suffers many exacerbations.

It would mean a different nursing plan again if the disease had progressed to phase three. Here we consider the patients with rheumatoid arthritis of long duration. The problems are plentiful. There is immobilization due to crippling.

Fortunately, most rheumatoid arthritics are hospitalized at the onset for a period, depending upon the complexity or severity of the problem that they present. It is during this time that the foundation for your entire plan can be laid. From your first contact with your patients you can create an impression which may mean a stepping-stone, or a stumbling block.

Now is the time to feed the hunger of the patient and his relatives regarding the *whys* and *wherefores* of this disease, through a carefully planned health teaching program. "What should Mr. and Mrs. Rheumatoid Arthritis and the relatives know? Perhaps the first question to ask is, "What do *I* know, and what can I learn about this disease, in order to be able to teach properly?

It is not too late for review and research into all aspects of this disease. This may also spark your incentive, for once having reviewed the disease, the need for health teaching will be seen distinctly and will be motivation for you. What a challenge each phase of the disease represents to your ingenuity and initiative!

Prolonged rest, without specific instruction in bed positioning and joint mobilization, may lead to rapidly-appearing deformities and restriction of joint movement. Rest, an important tool, can turn into a two-edged weapon! How would you aid in the control of pain, in the maintenance of the best functional range of motion in the joints, and in the preservation of strength of the muscles activating the

Mrs. Orton-Johnson is instructor in medical nursing at Regina General Hospital, Regina, Sask.

joints, when the patient is in the acute stage?

Have you considered how important the bed of the patient is? Is there a firm mattress well-supported by a fracture board that will give your patient support? Are the number of pillows kept to a maximum? It is easier to prevent flexion contractures than to correct them. Are the bed clothes warm? Have you eased the weight of the clothes from the patient?

The physical therapist plays an important role in keeping your patient a functioning member of society. Have you taken the time to observe her activity with your patient? You might supervise your patient during some of her active exercise periods especially when the physiotherapist is not present.

Guidance and teaching all along the way, for example by demonstration or conference with the patient and his relatives, is part of your responsibility as a nurse. Rest, adequate nutrition, proper body mechanics, body alignment and positioning, exercise, normal function of the bowels and bladder, general hygiene are only some factors that must be considered in the care of the patient at home, as well as in the hospital. The effect of a carefully devised plan will be most evident.

You must be sensitive to the total needs of the patient and his family if you are going to help him to find opportunities to express his feelings and to discover practical means for combatting his problems. Complete nursing service for the rheumatoid arthritis patient and his family is not possible without consideration of the emotional, social and economic factors that relate to the illness. Certainly, as a nurse, you cannot be expected to cope with all of the problems that evolve. You can be useful in correlating the efforts of the team, and you can act as a liaison between the members of the team. You can direct the patient in need of aid, concerning a special problem to the proper source for help.

If you harbor the ability to improvise, create, supplement, extend it to its limit for your patient. You may reduce a mountain to a hill for the patient who is in some way handicapped.

Observe your patient as an individual, and see his needs. One plan could not function for every patient. Look into the reservoir of your abilities, and air them all. You may never cure, but you can be of assistance to each Mr. and Mrs. Rheumatoid Arthritis.

How does the heart muscle keep going when hardening of the arteries is gradually choking off its oxygen supply?

Dr. Charles R. Park, a Vanderbilt University physiologist, suggests that the heart may have a built-in protective mechanism that produces energy without requiring oxygen in the cells. In Dr. Park's view, when the heart muscle is gradually being starved for oxygen by narrowing of the coronary arteries, glucose moves more rapidly than normally into the muscle cells. Here, by a complex chemical cycle, it is turned into energy without use of oxygen.

This theory was originally suggested by a group of British bio-chemists, one of whom is Dr. Howard E. Morgan. Dr. Park and Dr. Morgan are now testing this theory. Their method is to use a rat heart which is kept beating in laboratory apparatus that bathes it with a nutrient solution. First, they measure the amount of glucose which the heart muscle takes up from the solution in the presence of oxygen. Then they substitute nitrogen for the oxygen and observe any changes in the rate of glucose uptake by the cells.

Dr. Park reports that the phenomenon may explain more than how the heart muscle keeps going with clogged coronary arteries. That is, it may explain in part the increase in glucose utilization with muscular exercise.

— American Heart Association

* * *

In June, 1960 the commemoration of the Centenary of the opening of the **National Hospital,** Queen Square, London W.C.I. will be celebrated.

I should be glad to hear from any former members of the nursing staff who would like to take part in these celebrations or to receive notices or reports on them.

I am also anxious to have any information, including anecdotes, which may help in compiling the story of the growth and development of the nursing service of this hospital.

MARGERY LING,
Matron

Physiotherapy in Rheumatoid Arthritis

NANCY LAURIE, M.E.S.P.

The care of the patient with rheumatoid arthritis must include a carefully planned program of joint movements. This is of value in avoiding the incapacitating crippling effects of the condition.

THE PHYSIOTHERAPEUTIC treatment of rheumatoid arthritis is given under the direction of the physician. The progression of the treatment varies enormously from patient to patient as the disease itself can vary, but the general plan is much the same.

During the acute stage when the patient is on bedrest, the prevention of deformities is the main objective. This can be done by maintaining proper posture of the patient's limbs and body. The physiotherapist should move each joint through its full range at least once a day.

When the pain has subsided slightly, gentle active exercises can be started. These should not be enough to tire the patient. Hands, elbows, shoulders, feet, knees and hips should be included. Static contractions of the quadriceps are especially important. Strong quadriceps are necessary for walking, for preventing flexion deformity of the knees, and for relieving strain on the knee joints. A Balkan frame and an overhead sling can be used at this stage. They are especially useful for movements of the shoulder and hip joints since they give a good range of motion to these joints with little muscle work involved. Gravity and the friction of the limb on the bed are eliminated. Deep breathing exercises are included to keep the rib-cage mobile. Mild infra red rays are useful before exercising. This relieves some pain and makes the movements easier to carry out.

When the patient becomes ambulant and can attend the physiotherapy department, heat is usually continued. Wax baths are useful for hands and feet as the heating effect surrounds the small joints. The previous regime of joint movements is continued and exercises are increased to include resisted work. There is always considerable muscle wasting due to disuse during the acute stage and to the pathological changes of the disease. The quadriceps are given increasing amounts of weight to lift. Springs are used as resistance for knees and hips. Various weight-and-pulley devices are used for strengthening shoulders and elbows. The mobility of the hips and knees is aided by bicycle riding; of the shoulders by overhead pulleys, large wall wheels, etc. Back strengthening exercises are given to maintain posture.

During the weekends or in the evenings when the patient is not attending the department, a simple set of exercises, such as the following, can be done on the ward and supervised by the nurse. Each movement should be done about five times to begin with, and then increased gradually according to the patient's tolerance keeping well within the fatigue limit.

1. Make fist; stretch out fingers.
2. Bend wrists forward and back. Turn them in circles.
3. Bend and straighten elbows.
4. Put fingers to shoulders, then stretch arms out to sides.
5. Put fingers to shoulders, then stretch arms overhead.
6. Put fingers to shoulders, then stretch arms forward at shoulder level.
7. Put fingers to shoulders, then circle elbows.
8. Bend and stretch knees.
9. Lift one leg at a time straight off bed.
10. Lie face down; lift one leg at a time straight off bed.
11. Lie face down; lift head and shoulders off bed.
12. Sit with legs over side of bed and swing them.

An exercise list should be given to the patient on discharge. Suggestions are given for arranging pulleys, etc. at home. The patient should be impressed with the necessity of keeping up a program of joint movements.

Miss Laurie is a physiotherapist at Regina General Hospital, Regina, Sask.



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Our President

Miss ALICE GIRARD has been made Assistant Director General, Nursing Service, at St. Luke's Hospital, Montreal. We, of National Office, extend to Miss Girard our warmest congratulations and we know, that in this, the officers and members of the Canadian Nurses' Association would most happily join us.

Convention Bound?

We have pleasure in confirming that the member lines of the Canadian Passenger Association have granted reduced fares on the Identification Certificate Plan for persons attending the CNA 30th Biennial Meeting in Halifax, N.S., June 19-24, 1960.

The authorized dates for the start of the **going** journey will be as follows:

From stations on western lines — all points west of Fort William and Armstrong, Ontario, June 13 to 21 inclusive, 1960.

From Newfoundland, June 13 to 21 inclusive, 1960.

From stations on eastern lines — Fort William and Armstrong, Ontario, and all points east thereof, except Newfoundland, June 16 to 24 inclusive, 1960.

This certificate entitles the nurse to travel for "one and a half fare," that is one way full fare and return half fare. The trip must be made within the authorized dates which extend 3 to 4 days before and after the convention.

Upon receipt of application for registration for the CNA Biennial Convention, the Round Trip Identification Certificate is sent to each registrant together with other convention material.

Local CNR representatives will keep in touch with the transportation chairman in each provincial nursing association to inform them regarding train schedules, connections, etc.

ICN Exchange of Privileges

One of the objectives of the International Council of Nurses is "to offer facilities for the promotion of international understanding." As one step toward this objective it maintains a program for exchange of privileges available to all nurses who are members of one of the national associations affiliated with the ICN.

During 1959 Canada received 54 nurses from 12 countries — Australia, New Zealand, Denmark, Finland, Great Britain, Holland, India, Nigeria, Norway, Sweden, South Africa, Switzerland and United States — for employment in almost every field of nursing. One nurse from Denmark applied for extension of time in Canada. National Office, with the cooperation of the provincial associations arranged study and observation programs for 25 nurses from seven countries.

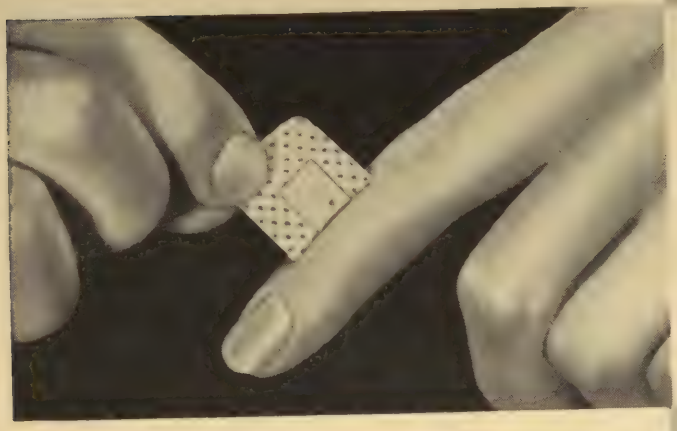
Canadian nurses have also taken advantage of this program. During the past year National Office has assisted 16 Canadian nurses to obtain employment in six different countries — Belgium, Denmark, England, France, Sweden and Switzerland. Study and observation programs have also been arranged for seven Canadian nurses in three different countries — Great Britain, Denmark and United States.

The CNA wishes to take this opportunity to pass on the gratitude and expressions of appreciation of all nurses participating in this program to the various associations and health agencies who have planned such interesting and varied programs. This association also wishes to express its appreciation to all national and provincial associations for their interest and cooperation

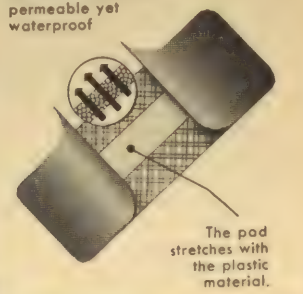
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Elastoplast 'Airstrip' is made from a specially developed plastic material, through which sweat and skin exudates evaporate at the same rate as they develop on the skin. The material is a micro-porous extensible filter, and is not perforated. It provides a barrier to water, grease, oil and infective organisms. Even after long application, Elastoplast 'Airstrip' does not cause maceration. The adhesive is specially spread in a lattice pattern so that micro-porosity is retained and firm adhesion not impaired. The surface of the wound and the surrounding skin remain dry beneath an 'Airstrip' dressing, which can be left on until the wound heals.

Elastoplast 'Airstrip' is available to the medical profession in cartons of:—

100 dressings 1½" x ⅞" (Order No. 7950)

100 dressings 2¼" x ⅞" (Order No. 7951)

50 dressings 1½" x 1½" (Order No. 7952)

50 dressings 2¼" x 1½" (Order No. 7953

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50 dressings 2 " x 3 " (Order No. 7956)

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in the planning of programs for both visitors and Canadian nurses travelling abroad.

CNA National Office welcomes any inquiries or requests from Canadian nurses and urges them to take advantage of this program. In this way you are assured of a warm welcome and the full cooperation of member associations of ICN.

International Visitors

A welcome is extended by CNA to three nurses from England on Study Scholarships who are visiting Canada during April for Observational Study Programs.

Miss **Phyllis Friend,** matron designate of the London Hospital, Whitechapel, London, will be visiting hospitals and schools of nursing in Vancouver, Victoria, Calgary, Toronto, Ottawa and Montreal. Her interests are in hospital administration and planning, and nursing education.

Miss **Marjory A. Priest,** principal sister tutor, Bristol Royal Hospital will be concentrating her study of nursing education in Toronto, Ottawa and Montreal.

Mr. **Clifford H. Scowcroft,** principal tutor, Penderfields General Hospital, Wakefield, Yorks., is also interested in studying methods and types of Nursing Education Programs, and will be visiting Windsor, Toronto, Ottawa and Montreal.

The exchange of information and ideas in all areas of nursing is most beneficial both to the host associations and agencies and to the visitors.

National Office Activities

In preparation for the CNA Executive Committee annual meeting in Ottawa, February 1960, National Office reviewed its activities of the past year. Many of these activities have already been recorded in this column and on other pages of *The Canadian Nurse.*

The following statistics might prove interesting. It seems almost unbelievable but in 1959 CNA conducted 34 meetings. CNA also participated in many meetings of other associations.

National Office representatives attended five provincial annual meetings. Addresses were delivered at four of these meetings, representing a total audience of 5725. Assistance has also been given with five institutes or conferences.

One of the objectives of the CNA is "to promote the best interests of the nurses of Canada and to maintain national unity among them." The remoteness one feels to individual CNA members often appears to be a disadvantage in the promotion of this objective but when one considers the above and the fact that in the past year 3865 letters were received in and 6837 mailed from National Office this problem is not as great as it appears. In addition, 10336 copies of CNA publications both in French and English were distributed from this office.

This is only a brief and by no means complete picture of the daily activities of National Office. One other item that we feel will interest you is the frequency of requests for assistance in the publication of various articles on nursing. Recently information on nursing in Canada was supplied for an article published in *Reader's Digest.*

Material has been supplied which will be incorporated into the revised edition of the textbook "Thresholds to Professional Nursing Practice" written by Miss Frances McKenna, USA. Articles have also been written for "The Record" published by the National Council of Hospital Auxiliaries of Canada and for the Alumnae Association of the Johns Hopkins Hospital School of Nursing.

Though man a thinking being is defined,
Few use the grand prerogative of mind.
How few think justly of the thinking few!
How many never think, yet think they do!

— Jane Taylor

* * *

Man is cleverer with his hands than with his head. He invents things and alters the whole condition of his environment, but he lags behind in adjusting his thoughts and the customs and institutions which organize his community life to the new way of life that his inventiveness has created. He is forever putting new wine into old skins, and is surprised when the skins burst.

— Leonard Behrens

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Just *one* second of prep time needed . . . with the modern FLEET ENEMA! Once the full-length protective cover has been removed and the prelubricated *2-inch* rectal tube has been inserted, simple manual pressure does the rest. And *after* the enema — no scrubbing, no sterilization, no setting up for re-use. The complete FLEET ENEMA unit is simply *discarded!*

why more and more hospitals are using the FLEET ENEMA

An efficient, economically-priced, *safe* enema requiring far less time than outmoded procedures, FLEET ENEMA also avoids the ordeal of injecting large quantities of fluid into the bowel.

Left colon catharsis can be achieved in *two to five* minutes without causing pain or spasm,[1] while affording the same cleansing efficacy as the usual enema of one or two pints. Reverse flow and leakage are prevented and a comfortable flow rate assured by the construction of the anatomically correct plastic tube.

Each Single-Dose Disposable Unit contains, in each 100 cc.:

Sodium acid phosphate USP.....16 G.
Sodium phosphate USP..... 6 G.

Plastic "squeeze-bottles" of 4½ fluid ounces, with prelubricated tip.

1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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NURSING PROFILES

Alice Wetmore Potter has been appointed educational consultant on the staff of the Brunswick Association of Registered Nurses.

A native of St. George, New Brunswick, Mrs. Potter attended Acadia University, Teachers College, Fredericton and the University of New Brunswick. She taught school in her native province for five years before entering nursing at Presbyterian Hospital, New York City. Following graduation Mrs. Potter was an acting head nurse in her home hospital and an industrial nurse in Long Island. In 1949 she graduated from Teachers College, Columbia University with a Bachelor of Science degree and went on to obtain her Master of Arts in guidance and student personnel.

Mrs. Potter served first as pediatric supervisor, Babies' Hospital, N.Y., then as surgical supervisor at the Columbia University Student Health Centre.

Her interest in academic pursuits took her back to Columbia where she has obtained post-master's credits in sociology, social psychology, mental health, curriculum and instruction.

While a U.S. army captain, she was head nurse, medicine and supervisor of fracture service.

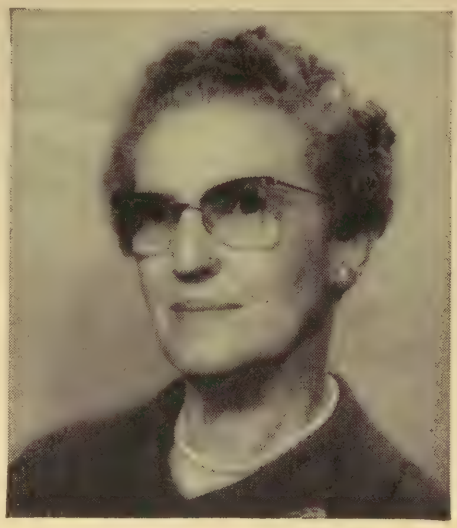
Her social activities include membership in the Women's Faculty Club of Columbia University, the Ballet Club, Museum of Modern Art and Business and Professional Women's Club, all of N.Y.C. In her leisure Mrs. Potter is a bird-watcher and golfer.

Edith Rainsford Dick has been appointed chairman of the Volunteer Nursing Service of Ontario division, Canadian Red Cross Society.

Born and educated in Milton, Ontario, Miss Dick left the University of Toronto after two years in arts to enter the Johns Hopkins Hospital School of Nursing in Baltimore. She returned to the University of Toronto to complete requirements for her B.A. degree and also obtained her certificate in public health nursing.

From 1932 to 1935, she was engaged in administration and supervision in the Ontario Mental Hospitals. Until 1940, when she enlisted in the RCAMC, she was inspector of Training School for Nurses in Ontario. When she was released from active service in 1945 she held the rank of Major (Prin. Matron). She was awarded the Royal Red Cross, first class, in June, 1944.

Since the war Miss Dick has been acting director of the Nurse Registration Branch, Ontario Department of Health.



(Canadian Pictures Ltd.)

EDNA M. SQUIRES

Edna M. Squires recently retired from the Ontario Department of Health's Division of Public Health Nursing after 38 years of service.

Following graduation from Toronto General Hospital in 1916, Miss Squires spent four years as a staff nurse at T.G.H. before taking a position with Union Carbide in Hamilton. In 1921 she joined the Ontario Department of Health, first with the Division of Industrial Hygiene, and later with the Division of Maternal and Child Health and Public Health Nursing. She spent many years in Rainy River District and in Eastern Ontario counties demonstrating public health nursing in the rural areas. Since 1952 she has held the position as assistant to the director in the Division of Public Health Nursing.

Sheila Margaret Lilian Nixon, Manitoba's editorial advisor to *The Canadian Nurse,* has been made nursing consultant in the Division of Hospital Standards, Manitoba Hospital Services Plan.

Miss Nixon, who was born in England came to Canada at an early age. She is a graduate of the Toronto General Hospital

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- DIAPARENE PERI-ANAL CREME—A safe efficient cream developed especially for the new-born with sore-bottom caused by loose stools, and diarrhoea. For effective treatment and prevention apply at diaper changes to the anal area.

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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and the University of Western Ontario, where she secured a Bachelor of Science degree. In 1958 Miss Nixon attended Teachers College, Columbia University graduating with a Master of Arts degree in Administration in Nursing Education.

During the war she served as a V.A.D.



SHEILA NIXON

in the British Red Cross Society attached to the Royal Navy. In 1943 she was awarded the Associate Royal Red Cross for meritorious service in Egypt.

To her new position she brings the experience of having been assistant director in nursing at the Ottawa Civic Hospital and director of nursing of Children's Hospital, Winnipeg.

In her leisure time Miss Nixon enjoys music, reading and swimming.

After 27 years with the Child Health Association in Montreal, **Ethel Blanche Cooke** has retired. She was born in Arundel, Quebec, where she received her early education, following which she attended Macdonald College, School for Teachers.

After graduation from the Montreal General Hospital in 1928, she did private nursing. In 1932 she obtained her certificate in public health nursing from the McGill School for Graduate Nurses following which she joined the staff of the Child Welfare Association of Montreal. Five years later Miss Cooke was supervisor of the Chandler Health Centre. At the time of her retirement she was Educational Director of the Child Health Association.

To anyone who had contact with Miss Cooke, it was obvious that she enjoyed her work with children, their parents, her staff and the many McGill students who came to the agency for experience.

Eleanor Gertrude Johnson is now the educational director, Chandler Health Centre of the Child Health Association, Montreal.

Miss Johnson was born in Charlottetown, P.E.I., attended school there and at Mount Allison Ladies College, in New Brunswick. She received her basic nursing education at the Royal Victoria Hospital in Montreal, then engaged in private nursing for 11 years.

Her postgraduate education includes certificates in public health nursing, administration and supervision in public health nursing from the McGill School for Graduate Nurses, and in leadership training in parent education from the Mental Hygiene Institute, Montreal.

Prior to her present appointment, Miss Johnson was director, Social Service Department, Veteran's Welfare Centre of the Canadian Red Cross Society. In 1948 she joined the Verdun Branch of the Child Health Association as senior nurse. She became the supervisor in 1953.

During World War II Miss Johnson served with the RCAMC as Lieutenant (Nursing Sister) in England, Italy and Canada.

Miss Johnson is a member of the United Services Club and enjoys photography and touring the country in her Volkswagen.



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Pearl C. Graham has retired after nearly 28 years of Nursing Service with the Ontario Department of Health, Mental Hospitals Division.

Following graduation in 1932 from the Ontario Hospital School for Nurses in Whitby she served as head nurse and night supervisor at her home hospital. Her postgraduate studies include a year in the psychiatric nursing course at Whitby and nursing education and administration at the University of Toronto School of Nursing.

Miss Graham, as a member of the teaching staff of the Ontario Hospital, London, assisted in the initiation of a course of affiliation in psychiatric nursing. A little later she became assistant director of nursing there. In 1940 she transferred to the Ontario Hospital, New Toronto, where, in 1942, she was appointed director of nursing, a post she held until her retirement.

She is now living in Barrie where she enjoys reading and hockey in the winter, and when spring permits, her favorite pastime, gardening. Her host of friends and associates wish her a long and happy retirement after loyal and dedicated service.

Florence Gruchy has retired after 40 years of missionary work in India.

Born in France, she came to Canada as a child to join her brothers who were homesteaders at Strasbourg, Saskatchewan. Following graduation from the University of Saskatchewan in 1916, she entered nursing at the Winnipeg General Hospital.

Through the Women's Missionary Society of the United Church of Canada, Miss Gruchy went to Banswara, India as nursing superintendent of a new hospital. In 1935 she left Banswara to become superintendent at Rutlam Hospital, then Hat Piplia Hospital and finally Indore Hospital, where she remained until her retirement.

Her main work in Indian nursing was the education of Indian Christian nurses and the growth of the profession. She inaugurated the Mid-India Board of Examiners for nurses, was its first secretary and has been in close association with it for 30 years. Part of the board's work entailed translation and printing of textbooks. Miss Gruchy spent a year learning Hindi on her arrival in India.

The Nurses' Auxiliary of the Christian Medical Association of India was organized with the help of Miss Gruchy. Throughout her association with nursing education she emphasized cultural pursuits for students.

In recognition of her tremendous contribution and outstanding service to nursing in India, she was presented with a silver replica of Florence Nightingale's lamp.

Miss Gruchy now resides in Neville, Sask. with her sister, Dr. Lydia Gruchy, who was the first woman to be ordained in the United Church of Canada.

Audrey Margaret Shiach has been appointed associate director of nursing education at the Atkinson School of Nursing of Toronto Western Hospital.



(*Le Roy Toll*)

AUDREY SHIACH

Born and educated in Toronto, Miss Shiach received her basic nursing education at McMaster University in Hamilton. Here she obtained her Bachelor of Science degree and a certificate in ward administration, supervision and teaching. On graduation, Miss Shiach did general staff nursing, then spent seven years as a clinical instructor in medicine at T.W.H. Prior to her recent appointment she was clinical coordinator and assistant director of nursing education also at T.W.H.

A man should always consider how much he has more than he wants and how much more unhappy he might be than he really is.
— JOSEPH ADDISON

The reader who is illumined is, in a real sense the poem. — H. M. TOMLINSON

* * *

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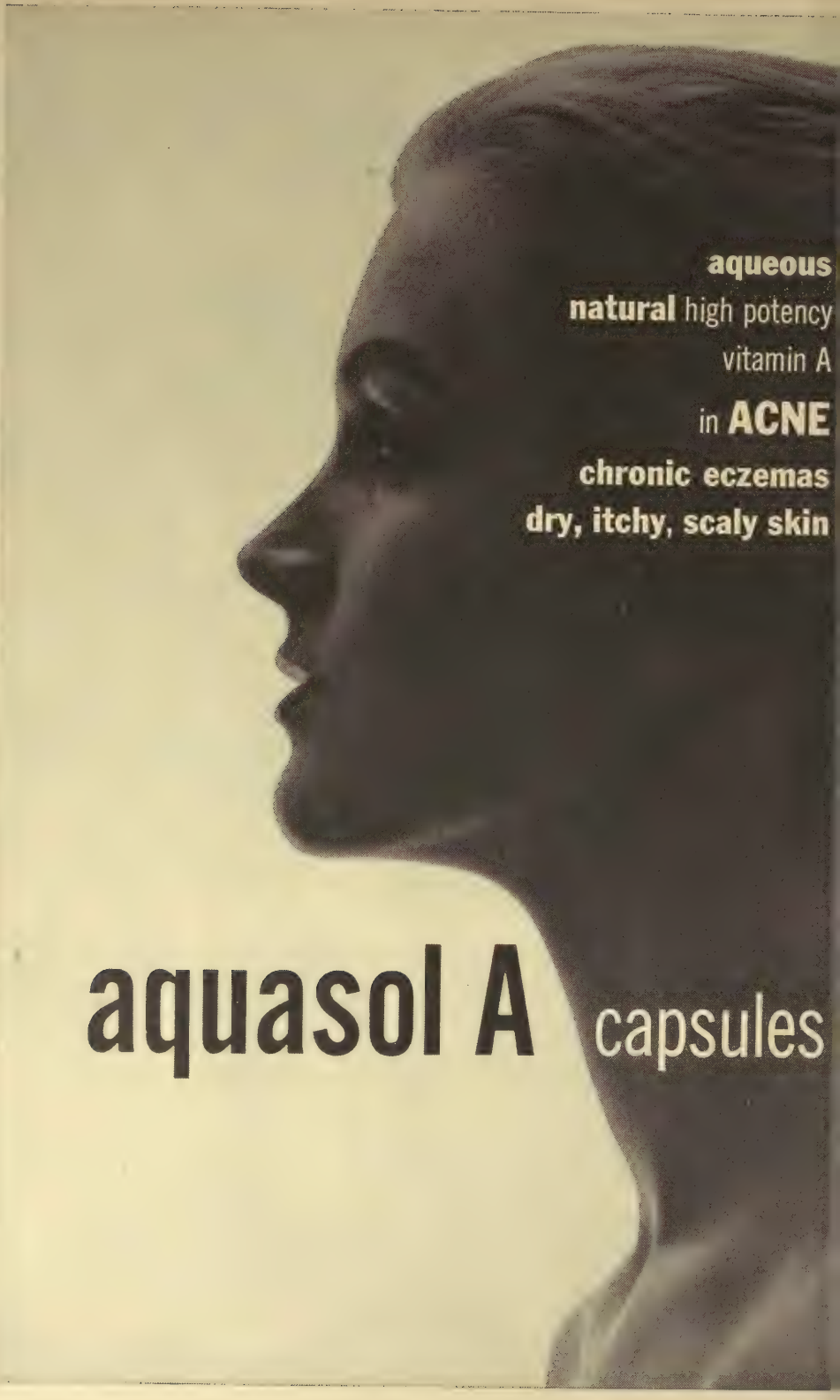
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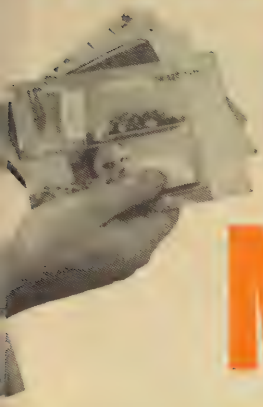
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1. Davidson, D. D. and Sobel, A. E., Jl. Invest. Derm. 12:221, 1949.


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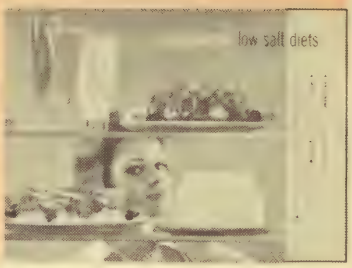
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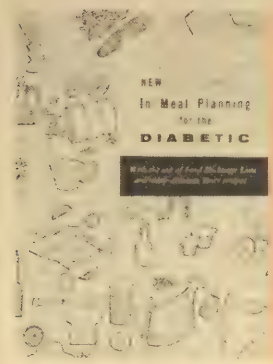
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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.



Play Therapy and the Nurse

Françoise Miller Ouellet, B.Sc., Ed.N.

Occupying the free time of the hospitalized child envelops, in the simplicity proper to that age, the whole process of curing illness, supervising growth and development, carrying on school lessons so that basically this is a program of rehabilitation rather than play therapy which begins at the time of admission.

As an introduction to this study the organization of leisure-time must be assigned to a specific area within the scope of education and general development. Leisure time may be defined as the hours within the course of a day which are not devoted to work or to rest. It is a time for recreation and relaxation, for vacation. This is the usual meaning that we associate with the term leisure.

However, another and much more dynamic interpretation can be made. If we identify leisure time with the various activities, games or sports in which the individual can indulge, then we can define it as an opportunity to promote development of the well-balanced individual. It can include both indoor and outdoor sports, walking, travelling, reading, studying, manual work, family parties and other social functions.

Children, as well as adults, have free time that should be spent in a healthful way. The child who is hospitalized must have this free time planned for him. The primary objective in organizing a program of recreational therapy is to help the ill and to round out their course of treatment.

It is now generally acknowledged that education can be carried on through play therapy. This was confirmed by Maria Montessori in her book "Scientific Pedagogy." It is a method that is presently being used in primary schools the world over as well as in some secondary schools.

There is very good reason then to organize a recreational program especially where a long period of hospitalization can be expected as, for example, in bone conditions, poliomyelitis, acute rheumatism, some types of skin grafting and esophageal strictures.

Mrs. Ouellet teaches chemistry and bacteriology at St. Justine's Hospital, Montreal and is the mother of two small children. This is the first section of her article on the importance of a recreational program in hospital.

Physiological Factors

As a beginning we can consider the biological needs of the child of 10-13 years and decide whether or not there is a definite need for such a program.

In hospital the child is subjected to a predetermined routine that includes treatment-exercise and recreation. One cannot ignore the physiological principles which direct the organization of free time and allow the children to have the benefit of regular hours of relaxation and exercise outdoors. Without this both mental and physical well-being would suffer.

Health is an entity. Illness or physical disability, depending upon certain psychical factors, can arouse a multitude of phenomena that are sometimes more marked in the child. The difficulty that he finds in adjusting to the environment within the hospital depresses and wearies him. At this particular age the child possesses tremendous possibilities, physically and mentally, and requires opportunities for self-expression. Leisure-time activities should provide an environment in which the child can learn through experience and his personality develop to the full. The physiological needs of active, creative children always remain the same.

Psychological Factors

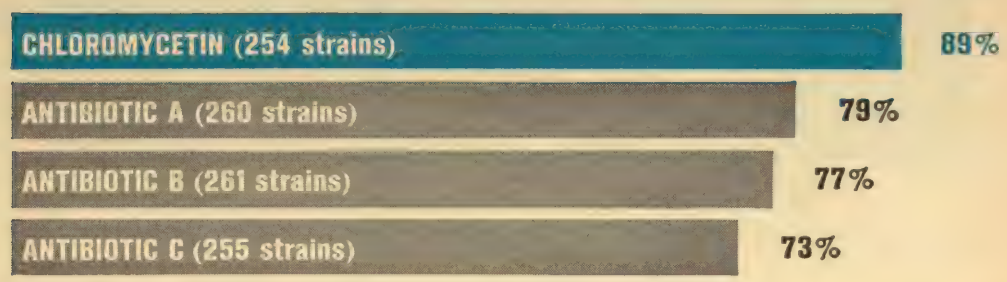
Because they affect life as a whole these factors require consideration. At home, the child plays because it is the natural thing for him to do. During illness the child has had to fight an infection although he has been unaware of this. As he recovers his strength,

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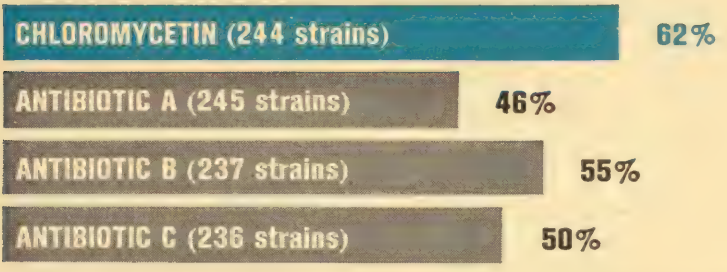
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he expects to resume his customary amount of activity and will not accept restrictions very happily.

Unlike the adult, the child is in a constant state of change. His growth is not arrested by illness or convalescence; but sometimes slowly, sometimes more quickly his physical, intellectual and emotional development goes on right through his period of hospitalization.

Through play, the child prepares for life as an adult. He learns to live as a reasonable, interested, cultured individual using the free time at his disposal to greatest advantage. Often his leisure-time activities reveal areas of interest that will always have an attraction for him and through which he will be able to develop his special abilities and talents. This may even be a means of helping the individual to decide on a vocation. Finally, recreation acts like a valve to channel the need for excitement and physical activity that arises from the superabundance of activity characteristic of the child.

The child's attitudes, interests and goals help to show us what his leisure-time means to him. He may tell us quite seriously "I have just come from work" believing rightly or wrongly that he has been helping the nurse. His so-called work is really a game if he goes about it of his own free will. The nurse's role will be to guide the child's activities while respecting his freedom as much as possible. Free time should provide a change from bed and medical treatments. The child should have a chance to shout and romp but the nurse must temper such frollicking so that the energy burned up does not exceed the degree of recuperation.

Moral Factors

Play time can provide an excellent opportunity for instilling moral values. Free time is necessary for physical and emotional relaxation but it can also be an opportunity for self-improvement. Children always experience so much joy and satisfaction from play that it is constantly necessary to help them achieve a proper balance.

The child must be helped to see that there is a time for work as well as for play; that there are certain limits to be accepted. He must realize that play-time cannot be allowed to interfere with his progress as a whole; that limitations have to be set in sports

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when there is the possibility that such a balance will be upset. Generally speaking, however, most sports call for intelligence, imagination, initiative, sensitivity, memory. They tend to develop such qualities as courage, will power, daring, tenacity, self-control, frankness, loyalty and particularly team spirit or the spirit of mutual aid — "one for all and all for one." The nurse can help the child to see his role as a team member through the help that he gives to others. She helps the child prepare to face the problems of life and to realize the interdependance between human beings.

It is important, then, that children should develop in an environment that emphasizes what is good, beautiful and true. Their leisure-time activities may determine whether or not their future lives will be happy or unhappy. What the everyday world lacks in beauty should be compensated for through recreation. It is from this that the great responsibility of parents, educators and hospital personnel derives.

Recreational Activities for the 10-13 year old Child

Any person who assumes responsibility for the care of a child must provide total care — physical, mental, spiritual and emotional. Means of providing amusement for him would fill a book — plastic work, soap sculpture, knitting, toy-making, weaving, leatherwork, music, marionnettes, felt-work, sketching, basket weaving etc.

Physical Organization:

As a first step in providing a recreational program, there should be a special area set aside for this purpose to give the child a change of scene, to take him out of an environment of illness and provide an opportunity for social contact with other boys and girls. It would be even more desirable to have two or three rooms large enough so that children who are up and about or who can get around on crutches, etc., may be able to move freely. The nurse should see to it that the arrangement of the department encourages this. It should even be possible to bring patients in their beds so that bedridden children can participate as well.

One section of the department should be set up as a library. There should be a variety of reading material arranged according to its content and the ages of the readers. There should be a card system to ensure proper rotation and return of the books.

Another section should have tables holding all the equipment necessary for manual work — either for teaching purposes or for use by the children. These require special and careful planning. There should be a table set up for leatherwork with a small work board, plastic material, tracing-awl etc.; one for artwork with paper, pencils, rulers, paints; another for needlework.

Finally, the third section should be for games — ping pong, dominos, puzzles of all kinds, card games, checkers, doll house furniture, etc. Cupboards and bins will be needed for storage space and a toilet, wash-stand and a cloakroom will be equally necessary.

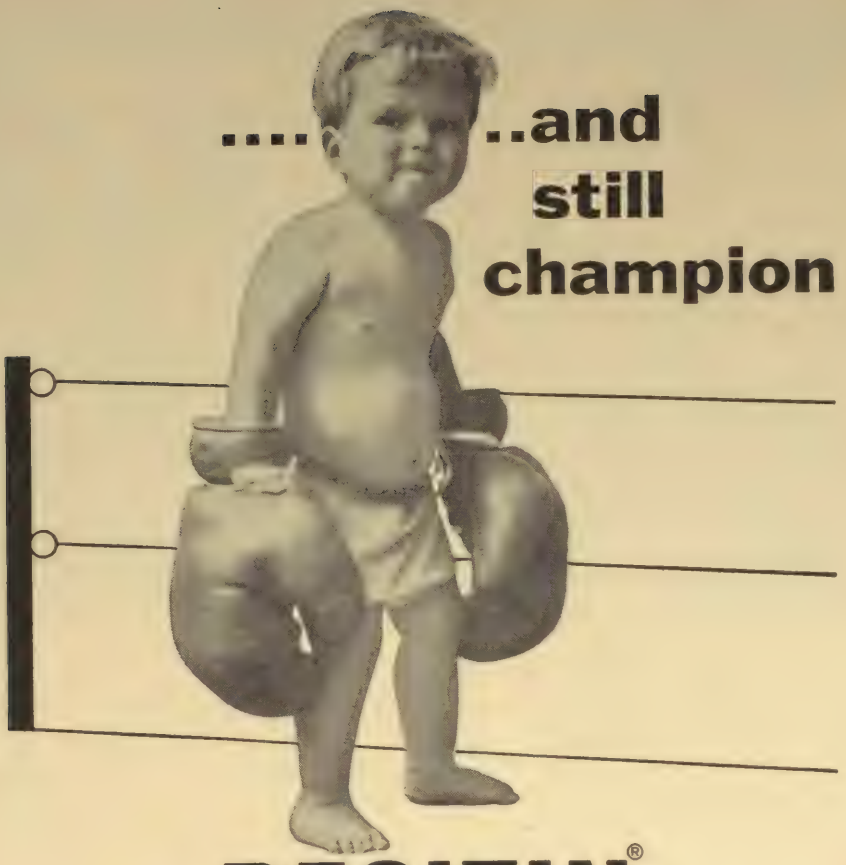
Reading Material:

Books for a children's library must be carefully selected. The interests of the child, his age, the external appearance of the book plus other factors must be considered. The nurse should have a good idea of the content of each book and should guide the child's reading but without forcing his interest in any one direction. Interests vary — what is pushed aside today will be eagerly sought tomorrow. A library suitable for children 10-13 years old should contain books on adventure, history, poetry, science and music as well as animal stories, fairy tales, sociological stories, humorous stories, classics.

Manual Work:

As far as games and specific occupations are concerned, certain ones are specially adapted for use by children who must remain in bed while others can be carried out equally well by bedridden or ambulatory patients.

The use of the marionnette is particularly worthwhile. The little figure comes alive in the hands of the child and puts into action what the human cannot express. Equally suitable are the little hand puppets. The youngster furnishes the conversation and makes the puppet perform all sorts of characteristic movements or mimicry either related to an imaginary character, a hospital situation, etc.



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Ideally there should be a teacher to guide the children who are interested in art. The paints used must not be of a toxic variety. Children with respiratory conditions must be carefully screened before they are permitted to participate.

Painting figurines is a pleasant pastime for anyone. Pretty replicas of Dresden china can be produced without requiring firing or baking. A special paint applied to the model gives a good ceramic glaze.

As purely feminine occupations, basket-weaving, felt-work, knitting, sewing and embroidery are always of great interest to 10-13 year-old girls. Embroidery is an easy type of work. Little girls can work on tea napkins, dish towels, table centres, guest towels. Those who show special skill can be taught to smock baby clothes although the nurse will have to cut out the dress and stamp the design. Small girls also enjoy knitting — scarves, mittens, baby bootees, socks for themselves, baby vests, bonnets, shawls.

Leather embossing is generally learned at a more advanced stage. Everyone is interested because this work is something out of the ordinary and the articles that can be made are useful to the children. The materials required are much more complicated and expensive. Cutting, punching and outlining the pattern on the leather offers an opportunity for muscular exercise of the hands and fingers. Lacing calls for flexion and extension of the muscles of the arms and shoulders with pronation and supination of for forearms.

Old x-ray films can be used to make book markers and little baskets. A punch and colored wool are needed for this. Little girls particularly enjoy making shell or plastic jewellery. There is scope for a wide variety of patterns.

For those who like more ingenious forms of amusement, walnuts can be fashioned into a number of novelties and there is an opportunity for individual skill and imagination. Plum,

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date and cherry stones can be used in jewellery making.

Games:

Puzzles, dominos, card games, "cut-outs," and coloring pencils are suitable materials for this particular age group. They provide an opportunity for more direct social contact between the children thus developing their spirit of sociability.

Educational projects such as plant-growing can be included here and provide a whole range of lessons in nature. It is unfortunate that the attention of city children is not directed towards this end to a greater degree. However, it is never too late to do something about it. The nurse can open up new horizons which will either supplement or make up for what is lacking.

The coloring pencil reveals the creative spirit of children. All that is necessary is to provide drawing paper and encouragement. The children can also be given pictures that only require coloring which helps to develop a sense of harmony.

A familiar game, and one that is always popular, is the three-foot long string with the two ends tied together which can be made up into a number of patterns according to the arrangement of the cords. It strengthens the hands because it requires precision, finger stretching and contraction.

Musical chairs is another possibility. In seating themselves the children should try to maintain good posture.

Birthday celebrations are the order of the day in a children's hospital. Observance of this particular occasion for each child keeps him from feeling forgotten. It is the kind of thing that his mother would do for him.

Christmas is another big event. Not being an everyday occurrence, it should be prepared for very carefully. The age and tastes of the child should be considered in deciding upon a gift for him, so that he will receive maximum pleasure from it. Christmas scenes painted on the windows of the ward help create a festive atmosphere.

In view of what has been said, it can be seen that hospitalized children can carry on a number of activities, all of them worthwhile, and that there is no lack of resources. If the nurse takes her role in this program seriously and directs activities efficiently, it is unlikely that the children will tire of it.

To be continued next month.

In the Good Old Days

(*The Canadian Nurse* — APRIL, 1920)

A Canadian Flag

It has been proposed that the Federal Government be asked to adopt a distinctive Canadian flag. It is also suggested that an appropriate function be held once a year, preferably on Dominion Day, to receive publicly into Canadian citizenship those who have completed all the conditions of naturalization during the year.

* * *

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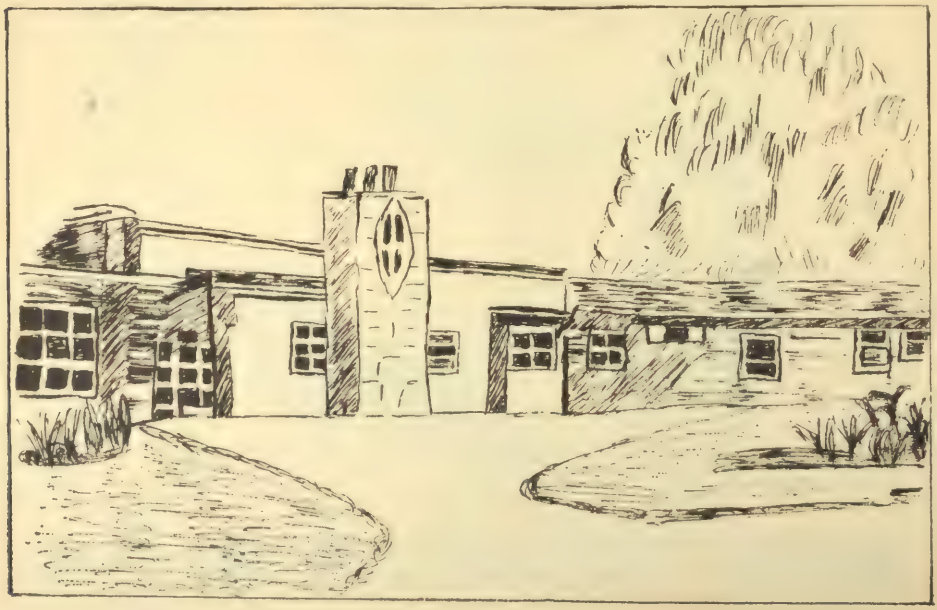
JEAN E. MACGREGOR, B.N.

Two conferences for nurses have been scheduled at Five Oaks for May 6-8 and November 4-6, 1960. Further information may be obtained from Rev. Beverly Oaten, Five Oaks Christian Workers Center, Paris, Ont.

JUST A SHORT DRIVE from Paris, Ontario and crowning a hill-top that overlooks the beautiful Grand River valley is Five Oaks Christian Workers Center — the center for the five conferences of the United Church of Canada in Ontario and Quebec. The modern, split-level, ranch-style main lodge — The House of the Interpreter — looks out over several acres of quiet, wooded countryside with the Grand River flowing peacefully on one side and Whiteman's Creek tumbling down in a miniature waterfall to meet it at the border of the grounds. Tucked beneath the brow of the hill are additional cabins for summertime use, tennis courts, baseball diamonds, nature trails. When operating at full, warm weather capacity, the Center can accommodate 135 overnight guests.

Five Oaks is attached to the work of the Board of Christian Education of the United Church of Canada. Its purpose — a simple but very basic one — is to help people to live their religion more effectively in their churches, in their homes and in their daily lives. Although related to a specific religious denomination, the first-time visitor to the Center soon becomes aware of the fact that no special emphasis is placed upon individual denominational connections. Persons of all faiths are welcome to attend conferences and do attend with the full consent of their clergy although they may not be of the Protestant or even of the Christian faith. As desired, the staff of the Center arranges to have visitors of other faiths attend religious services in churches of their choice. It is this broad-minded viewpoint — a reflection of the philosophy of its director, Rev. Beverly Oaten, and of his staff — that is making the work of the Center so effective.

A quick glance at a conference bulletin gives some idea of the scope of the program carried out. During 1960 conferences have been scheduled for teachers, nurses, dentists, rural resi-



Five Oaks

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By M. ESTHER McCLAIN, R.N., B.S., M.S.; and SHIRLEY HAWKE GRAGG, R.N., B.S.N. 1958, 3rd edition, 535 pages, 5½" x 8½", 128 illustrations. Price, $4.50.

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dents and civil servants. In addition, there are family weeks, courses for church school personnel, teenagers, etc. These courses vary in length from two days to one month. A service presently offered under the direction of experienced professional personnel is vocational guidance. Individuals 18 years of age and over who feel the need for direction in choosing a vocation, can have expert assistance at a very nominal fee. Special conferences designed to give advice, assistance and understanding on widely different topics are offered — for example, family life, international affairs. While "retreats" are an intimate part of the Roman Catholic faith, they are still a bit of a novelty to Protestant denominations. The Center offers several opportunities for retreats throughout the year — a chance to examine religious beliefs, to deepen or strengthen faith under guidance. The peaceful rural setting was chosen and is being carefully guarded against urbanization to ensure the serenity of environment in keeping with these periods of thought and study.

How does the work of Five Oaks contribute to our lives as nurses? A brief resumé of a conference held late in 1959 may be the most effective answer. The topic was a familiar and pertinent one — the care of the whole patient. How was it handled? An experienced industrial psychologist, Kenneth Cox, discussed the close interrelationship between the mind and the body. Ted Leighfield, staff associate at Five Oaks, drew upon his experience in the field of human relations to indicate the factors that promote, hinder or color communications between individuals. He stressed one factor in particular — the need to *listen* to what others are saying, to reflect and to arrive at a real understanding of what has been said. So often conflicts arise through misunderstanding or misinterpretation. A doctor of philosophy, Dr. P. Devadutt, professor of ecumenical theology at Colgate-Rochester Seminary in Rochester, N.Y., discussed the tremendous worth of human personality and its fragility. On the one hand, man can split the atom, die heroically on the battlefield, even bend nature to his will; and, on the other hand, he may become completely disorganized by a small accident. In our modern society we tend to lose sight of the individual, relationships become impersonal and that part of our nature that thrives upon warm relationships starves. The individual becomes "a cog in the wheel" — a situation that was never meant to be.

A concern of nursing education is to foster appreciation of the individual as a person. The entire conference stressed this theme.

Since the chief purpose of the Center is to promote more effective Christian living, Bible study under experienced direction and worship periods are an integral part of any conference. This provides an opportunity, as well, for discussion of problems arising in the practical application of Christianity. How should the trouble-maker on the nursing staff be dealt with? How concerned should professional, service-centred people be about money-making? Are we becoming too materialistic?

The program was carefully planned but very flexible. A steering committee chosen from the conference members advised the director at frequent intervals as to group progress. Speakers returned to the Center for further discussion or stayed on, if from a distance, at the request of the delegates. Every possible effort was put forth to ensure that the needs of the group were met. This policy of avoiding strict adherence to a program is observed at all conferences and guest speakers are always advised of it in advance.

The Center possesses a relatively small staff. The guests are organized into work parties to assist at meal times in particular and are encouraged to lend a helping hand with any special projects that are in progress. As a result the conferences at Five Oaks have another, and perhaps unplanned, effect. They provide good practical experience in cooperative effort and human relationships. As guests work together setting tables, serving, washing and drying dishes, reserve melts away and new friendships quickly form. Nor is the recreational side of things forgotten. Depending on the interests of the group, social activities may vary from dancing to a singsong around the huge stone fireplace in the lovely Upper Room.

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Presenile Dementia

JOHN GIBSON, M.B., CH.B., D.P.M.

Increasing longevity is focusing attention upon the conditions caused by the degenerative changes in the body. In this article, some of the diseases producing mental deterioration are reviewed.

THE TERM presenile dementia is used to describe certain degenerative diseases of the brain occurring in middle age, for the most part, and producing dementia. The most important are Alzheimer's disease, Pick's disease (not to be confused with the other Pick's disease, which is characterized by an enlarged liver and excessive amounts of fluid in the pericardial and peritoneal cavities), Jacob-Creutzfeldt's disease and Huntington's chorea. A number of other diseases have been described, but they are too rare to merit description here. The term "presenile" covers the period from 40 to 65 years, but presenile dementias have occurred in older and much younger patients. Huntington's chorea is an inherited disease; hereditary factors play a part in Alzheimer's disease and Pick's disease, but otherwise the causes of these conditions are unknown. All are incurable and progress remorselessly to a fatal termination.

Cerebral tumor, extradural hematoma, neurosyphilis, myxedema and chronic alcoholism may at one stage present a very similar picture to that of a presenile dementia. Appropriate investigation, including cerebrospinal fluid examination, air encephalography and studies of thyroid function, should be undertaken before a definite diagnosis of presenile dementia is made.

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the seventh of a series of articles on psychiatric subjects.

Alzheimer's Disease

In this condition the brain becomes atrophied, especially the cortex, which becomes much shrunken, but there are none of the limited local atrophic areas characteristic of Pick's disease. On microscopic examination of the brain two quite distinctive features are seen: (a) irregular silver-staining "plaques" of uncertain origin, and (b) an irregular thickening of the neurofibrils in many of the cortical cells. With the development of the disease the cells of the cortex disappear. The shrinking of the cortex and an enlargement of the ventricles is usually demonstrable in air studies of the brain.

The symptoms of the disease are those of dementia. Impairment of memory is usually the first. The patient forgets what he is going to do, what he has just done. He forgets where he has put things; he forgets appointments; he goes out shopping and forgets what he has gone for. He becomes careless and does not wash, brush his hair, or dress tidily. He ceases to work efficiently and shows lack of initiative. He fails to grasp problems previously well within his capabilities. His judgment becomes faulty; he makes foolish decisions and cannot appreciate his folly. He shows a tendency to futile repetition of action. That something is wrong may be apparent to his family, but hardly ever to himself. He may become euphoric, depressed or perplexed. Paranoid ideas may occur, but rarely hallucinations.



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As the disease progresses he shows aphasia. He is unable to express himself clearly in spoken or written speech. He fumbles for words. He cannot understand what he hears or tries to read. Speech is disjointed; words are senselessly repeated; nonsense words and phrases are uttered. He develops muscular weakness and spasticity. As a result he walks stiffly, cannot balance accurately, and may fall. Epileptic attacks may occur. A profound dementia is produced and death occurs within a few years of the onset.

No treatment is of any avail to stop the march of the dementia. The patient should be looked after at home for as long as possible and then admitted to a mental hospital. There, treatment is directed towards maintaining nutrition, providing simple employment for as long as possible, allaying excitement by sedatives, and in the later stages preventing bedsores.

Pick's Disease

In many ways this is similar to Alzheimer's disease. It is an incurable dementia beginning within the same age period, showing very much the same kinds of symptoms, and having an equally hopeless prognosis. It differs in: (a) not showing plaques and neurofibrillary changes in the brain; (b) showing localized "punched out" areas of cortical atrophy demonstrable by air encephalography; and (c) having a more definitely established hereditary basis. Clinically the disease shows itself in intellectual failure, emotional and speech disturbance, and proceeds to profound dementia and death. Treatment is as for Alzheimer's disease.

Jacob-Creutzfeldt's disease

This is much more rare than the other two forms just described. It is characterized pathologically by a much wider spread of degeneration in the brain. The thalamus, the basal ganglia and the cerebellum are involved as well as the cortex. In consequence, the patient shows both gross dementia and evidence of pyramidal and extrapyramidal involvement in the form of spasticity, ataxia, choreoathetosis and Parkinsonism. The disease runs a much more rapid course than the other dementias and is fatal within six months

Huntington's chorea

This is a familial disease characterized by the development of generalized choreiform movements and dementia. Its usual age of onset being between 30 and 50 years, it can be included among the presenile dementias. It is an inherited disease, transmitted by a single dominant gene and therefore inherited by half the children of an infected person. Both sexes are equally affected. The brain shows gross wasting involving both the cortex and the subcortical structures, and a chronic meningitis.

Although the disease does not usually develop before the age of 30, it has been known to occur much earlier. Mental disturbances may precede the onset of dementia, and a tendency to suicide is common. Mental symptoms usually precede the appearance of neurological signs and symptoms. Early symptoms are: bad temper, irritability, slovenliness of dress, hoarding of rubbish, carelessness and disregard of social conventions. Memory is, rather surprisingly, retained for a long time. In the end a profound dementia is produced.

The choreiform movements begin in the face, limbs or trunk and may affect one side before the other. In time they involve the whole voluntary musculature. Movements may be jerky and abrupt or more athetoid than choreic. Voluntary movement is interrupted and disorganized. Speech becomes increasingly difficult. When walking becomes impossible the patient becomes chair- or bed-ridden. The final picture is one of complete dementia, complete physical helplessness, and gross irregular movements that throw the patient about. The duration of the illness is from 10 to 15 years. Treatment is as for the other dementias. Because of the irregular movements, which are likely to rub off pieces of skin, the prevention of bedsores is of particular importance.

Every joy is gain and gain is gain, however small. — Robert Browning

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(Signed) K.S., M.D., New York, N.Y.

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In Memoriam

Nora Armstrong, a graduate of Dunedin Hospital, New Zealand in 1906, died in Regina, Sask. on January 12, 1960. In 1945 she was made an honorary member of the Saskatchewan Registered Nurses' Association.

* * *

Margaret Jean (McDougall) Chadwick who graduated from Union Hospital, Moose Jaw, Sask. in 1930 died in that city on January 21, 1960. She was actively engaged in nursing until January, 1959.

* * *

Janet (McVicar) Clare, a graduate of Victoria Hospital, London, Ont. in 1907, died during 1959.

* * *

Bertha Condran, a graduate of Long Island College Hospital, Brooklyn, U.S.A. died recently in North Woodside, N.S. She was employed for some time as an instructor at the Nova Scotia Hospital, Dartmouth.

* * *

Emma Cooper who graduated from the Royal Victoria Hospital, Montreal in 1896, died in England in December, 1959.

* * *

Lydia R. L. (Newell) Erickson, a graduate of the Victoria Union Hospital, Prince Albert, Sask. in 1941 died on November 16, 1959.

* * *

Sarah Isabel Holden, a graduate of Long Island School of Nursing, New York in 1912, died on February 9, 1960. At the outbreak of World War I, she joined the RCAMC and served in Salonika, Greece for most of her time overseas. For heroic service during this period she was invested with the Royal Red Cross by His Majesty, King George V. For the past seven years she has been a patient at the Ste Anne's Military Hospital, Ste Anne de Bellevue, P.Q. Miss Holden was 85 years of age.

* * *

Mary Victoria (Johnston) Hyndman who graduated from Victoria Hospital, London, Ont. in 1910 died during 1959.

* * *

Edith Gertrude Joynt, a graduate of Victoria Hospital, London in 1922, died during 1959.

* * *

Mary Anastasia (Mae) King, a member of the first graduating class of Charlottetown Hospital, P.E.I. died on February 7, 1960. She was in charge of the maternity division of that hospital 1918-45. Miss King was the first president of her alumnae association and a former president of the Association of Nurses of Prince Edward Island.

* * *

Jean (Ross) Lennox, a graduate of Sarnia General Hospital, Ont. in 1936, died in October, 1959.

* * *

Georgia L. MacFarlane who graduated from Prince County Hospital, Summerside, P.E.I. in 1925 died on February 4, 1960. During her professional life she was engaged in institutional and private nursing.

* * *

Nancy Gladys Mould, a graduate of Royal Inland Hospital, Kamloops in 1942 died on January 5, 1960. She was on the staff of the University Hospital, Saskatoon, Sask. at the time of her death.

* * *

Elsie B. Pomeroy, a member of the first graduating class of the Royal Victoria Hospital, Montreal in 1896 died on December 24, 1959.

* * *

Mrs. Alice Josephine Radford who graduated from Halifax Infirmary, N.S. in 1955 died during September 1959.

* * *

Nelly (Walters) Ringrose, a graduate of Victoria Hospital, London, Ont. in 1923, died on January 2, 1960. She was actively engaged in nursing up to the time of her death.

* * *

Audrey (Charters) Russell who graduated from Victoria Public Hospital, Fredericton, N.B. died on January 8, 1960 after a long illness.

* * *

Eleanor Hope Shackleton, a graduate from Guy's Hospital, London, England died in Victoria, B.C. on January 16, 1960. During World War I she served with the British Expeditionary Force in Egypt, Salonika and Gallipoli. She was a nursing sister of the Queen Alexandra Imperial Nursing Service. After coming to Victoria in 1944 she engaged in institutional and private nursing at the Royal Jubilee Hospital. She was 80 years old.

Things do not change; we change.

— THOREAU

Book Reviews

The Art, Science and Spirit of Nursing by Alice L. Price, R.N., M.A. 864 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 2nd ed. 1959. Price $5.50.

Reviewed by Miss M. Kullberg, Instructor, Children's Hospital, Winnipeg.

On first looking over this book, one would receive the impression that it would tend to "spoon feed" the students, that they would have no work to do. On closer examination you note that the outline with the material given helps the students to make their own notes.

The presentation is refreshing with the cartoons at the beginning of each chapter and excellent illustrations throughout. Even if the student does not read the book, at least she will derive some benefit from the illustrations.

Of course no text is perfect and so it is with this one. There are a few items that are not applicable to the Canadian situation, for example, the regulations set up by the Harrison Narcotic Law which relates to the American situation. Some of the diagnostic tests described might confuse the student in trying to decide which method is correct. This is also true of the chapter on surgical dressings. The feeling is that the method used is slightly antiquated — the use of the dressing cart or carriage. At the present time when more and more is being discovered about microorganisms, the use of the dressing cart has been abolished in some hospitals due to the greater possibility of contamination. Students try to find "short-cuts" wherever and whenever possible, and letting them view a technique such as this, is not good. The earlier chapter on surgical asepsis was very well explained. Surgical asepsis is one of the most difficult techniques from the point of view of student understanding. It is presented in such a way that students can easily comprehend principles.

Miss Price has incorporated related information from microbiology, anatomy and physiology, sociology, etc. into each chapter. This shows the students that nursing arts is not an isolated course but one that encompasses all others.

Last but not least, this is a text for the preclinical students especially, one that they *will* read and enjoy reading. It never goes

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above their level of learning without adequate explanation. At this stage in their nursing career they require such a book — one that eases them gradually into the nursing field.

Function of the Human Body by Arthur C. Guyton, M.D. 584 pages. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 1959. Price $7.50.

Reviewed by Sister Marie Monica, Charlottetown Hospital, Charlottetown, P.E.I.

This text is designed to present the intricate logic of the function of the body and the principles of homeostasis in a manner which can be readily understood by the student. This objective is admirably achieved in a relatively simple and concise manner.

The text begins with an introduction to human physiology and the organization of the human body. This is followed by a discussion of the cell and cellular environment. The following chapters are concerned with the physiology of the various systems. Although at times physiology tends to be rather complicated to our minds, this author makes a marvellous presentation of the subject matter that should be easily comprehended by the student. The numerous diagrams included in each chapter add greatly to the clarity.

More detail is presented than is necessary for the student to acquire. However, for the instructor this text should be of invaluable assistance in her preparation for teaching. The author is to be commended for his presentation of a text so well suited to meet the needs of both instructor and student. It contains a complete and scientifically accurate survey of the broad field of physiology.

Swire's Handbook for the Assistant Nurse. Edited and revised by Ruby T. Farnol, S.R.N., S.C.M., D.N. (London). 339 pages. The Macmillan Company of Canada Limited, 70 Bond St., Toronto. 4th ed. 1959. Price $2.75.

Reviewed by Miss Louise Brodie, Dept. of Health & Public Welfare, 320 Sherbrook St., Winnipeg 2.

This text was first published in 1949 to meet the needs of the assistant nurse who was then just beginning to take her place in the nursing profession. The author states that the text contains just the amount of knowledge that the assistant nurse is required to have, but it would seem that such is not the case.

In the first section dealing with anatomy

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and physiology, the skeletal system is discussed in considerable detail, including the names of all the bones (even those in the skull) and their various parts, processes and depressions while the other systems are dealt with in much less detail. In the second section "Personal and Communal Health," the only aspect of community health dealt with is that of sanitation. Here one finds considerable detail in regard to the proper type of equipment required for plumbing, heating and lighting, which it would seem is not in the assistant nurses' field.

Several nursing procedures such as hypodermic injections, intramuscular injections, catheterization, insertion of a pessary, are described in detail and yet it is noted that these procedures are carried out by the graduate nurse. One statement that seems erroneous, is that for a baby bath "the temperature of the water should be about 100°F., but as the child grows, this may be reduced to 85°F." Maybe English babies are of hardier stock than Canadian babies, but I would certainly hesitate to give a bath in water below body temperature, especially when one takes the trouble to warm the clothing!

* * *

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ALBERTA

Instructors of Nurses to teach students in 3-yr. psychiatric nursing program for 1,500-bed approved active treatment hospital. Salary range: $4,320 to $5,160 per yr. 40-hr. wk., civil service holidays, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply, stating qualifications & experiences to: Superintendent of Nurses, Provincial Mental Institute, P.O. Box 307, Edmonton, Alberta.

Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

Matron for 12-bed municipal hospital, located 15-mi. E. of Banff, Alberta, on the C.P.R. mainline, & the Trans Canada Highway. Employment to commence May 1, 1960. 40-hr. work wk., week-ends off. Live in. Room & board $30 per mo. Holidays — 28 calendar days after 1-year employment, & 9 statutory holidays. State salary expected. Apply in writing to the: Secretary-Treasurer, Municipal Hospital, Canmore, Alberta.

Registered General Duty Nurses for busy 45-bed hospital, with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr.wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

General Duty Nurses — Salary $3,480 - $4,080 per annum, 40-hr. work wk., Civil Service holiday, sick leave & pension programs. Apply to: Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurse for 17-bed hospital, 100-mi. north of Calgary, salary $265 gross with increments of $5.00 every 6-mo. for 3 increases, 44-hr. wk., 3-wk. vacation after 1-year of service, 10 statutory holidays, board & room $35 per mo. Apply: Municipal Hospital, Elnora, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

General Staff Nurse for 85-bed hospital, 15-bassinettes. Modern nurses' residence. 40-hr. wk., liberal personnel policies. Apply to: Director of Nursing, St. Joseph's General Hospital, Vegreville, Alberta.

BRITISH COLUMBIA

Registered Nurses (3) for 30-bed hospital. Starting salary $285 per mo. with $10 yearly increment. Past service recognized for salary purposes. Board & room $40, 1½ day sick leave per mo. 40-hr. wk. 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

Registered Nurses (3) for 30-bed hospital in Central B.C. on the Jasper-Prince Rupert Highway, 70-mi. from Prince George. Salary $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Kindly apply giving qualifications & references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

General Duty Nurses for small active hospital. Salary $260 for unregistered, $275 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. **Nurses Aides** — with vocational training. Salary $177-$201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270 Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with semi-annual increments of $5.00-$305; 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

MANITOBA

Science Instructor & Clinical Instructor for 250-bed Pediatric Hospital. School of nursing with 75 students & affiliate program. Salary according to education & experience. Apply to: Director of Nursing, Children's Hospital of Winnipeg, Winnipeg 3, Manitoba.

Matron for 35-bed General Hospital, in southern Manitoba. Duties to start immediately. Starting salary $350, room & board charged at $45 per mo., no charge for laundering separate residence, pleasant staff to work with. Apply: F. E. Dueck, Administrator, Altona District Hospital # 24, Box 660, Altona, Manitoba.

Registered Nurse (for duties of Matron), Registered Nurse &/or Practical Nurse (for general duties) for 11-bed Medical Nursing Unit. Good salaries & conditions. Apply: Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurse (Immediately) for 10-bed hospital, with possibility of being Matron in the near future, if interested. Salary for R.N. $310 per mo. with increments of $5.00 every 6-mo. for 4 years. Matron's salary $370 per mo. with same increments. For further particulars apply to: Mrs. Sheila McEwan, Secretary, Birch River Medical Nursing Unit, Birch River, Manitoba.

Registered Nurses (2) for 20-bed hospital. Salary: $300 per mo. gross. 40-hr. wk. with 4 annual increments of $10. 3-wk. vacation with pay after 1 full yr. employment, 4-wk. after 2 full years. Sick leave, 1 day for each full mo. of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Apply: Matron or A.C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurse over 30 years with at least 5-yr. experience & some administrative ability to act as Matron for modern 60-bed hospital. Salary: $360 with increments. Good living quarters. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered & Licensed Practical Nurse for General Duty. Gross monthly salary $310 for R.N., — $220 L.P., less $45 for full maintenance. Apply: John Hiscock, Secretary Treasurer, Medical Nursing Unit, Baldur, Manitoba.

Registered Nurses for Swan River Valley Hospital. Salary: $280 with 4 semi-annual increments to $300. 44-hr. wk., 3, 8-hr. rotating shifts. 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Daily bus service to points — north, south, east & west. Local golf club, flying club, curling club; good swimming, fishing, skating, etc. Apply: Swan River Valley Hospital, Swan River, Manitoba.

NEW BRUNSWICK

Nursing Superintendent for 14-bed community hospital. An opportunity for public service. Apply to: Superintendent, Grand Manan Hospital Ltd., North Head, Grand Manan Island, New Brunswick.

Science Instructor for the Moncton Hospital School of Nursing which has a yearly enrollment of 40 students. Salary based on qualifications, 40-hr. wk., good personnel policies. Apply to: Director of Nursing, The Moncton Hospital, Moncton, New Brunswick.

Registered Nurses (Immediately) for modern 25-bed hospital. Starting salary: $240 per mo. with bi-annual increases. Room & board in modern residence: $40 per mo. For further information write: Miss M. Giberson, Superintendent, Tobique Valley Hospital, Plaster Rock, New Brunswick.

NOVA SCOTIA

Registered Nurses for night and **Obs. Supervisors (Immediately).** Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1-yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

ONTARIO

Assistant to Director of Nursing Service to work afternoon & evening shifts rotating bi-weekly, 5-days per wk., in 100-bed active General Hospital. Excellent personnel policies & salary scale. Employer participation in pension plan. Personal interview will be arranged. Forward enquiries to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Supervisors (Delivery Room & Night) for 90-bed obstetrical hospital, postgraduate training & experience essential. For particulars apply to: Director of Nursing, Grace Hospital, Ottawa, Ontario.

Public Health Nursing Supervisors (2). Salary range $4,436 - $5,046 per annum; **Public Health Nurses** (10). Salary range $3,625 - $4,390 per annum, salary based on experience. (generalized program). Positions carry pensions, hospitalization, Blue Cross, medical & surgical care, accumulative sick leave & other privileges. Applications will be received by the newly organized Metropolitan Windsor Health Unit, 2090 Wyandotte Street E., Windsor, Ontario.

Registered Nurse as Superintendent (Immediately) for 30-bed hospital, stating previous experience & salary expected. Furnished 3 room apartment provided. Apply to: Secretary, Englehart & District Hospital Board, Box 609, Englehart, Ontario.

Head Nurse for very modern maternity department. Postgraduate course preferred, but experience would be considered. Good personnel policies. Apply: Director of Nursing, Greater Niagara General Hospital, Niagara Falls, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital. Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses for 100-bed active General Hospital. Good salary, personnel policies include 5-day work wk., 14-days paid sick leave accumulative, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan. Apply to: Director of Nursing. The Cottage Hospital, Pembroke, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic, Northwest Territories and the Yukon Territory.

SALARIES



(1) **Public Health Nursing Supervisors: up to $5,460 depending upon qualifications and location.**

(2) **Directors of Nursing in Hospitals: up to $5,400 depending upon qualifications and location.**

(3) **Public Health Staff Nurses: up to $4,050 per year depending upon qualifications and location.**

(4) **Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.**

(5) **Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.**

- **Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three week's annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.**
- **Special pay and leave allowances for those posted to isolated areas.**

For interesting challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for general duty nursing in all departments of hospital. Apply: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk., good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses for modern hospital, building expansion under way increasing to 100-beds this year. Starting salary $250 per mo., $215 for Graduates. 40-hr. wk., group life, accident & sickness insurance free to employees. Opportunities for advancement, pleasant community. Apply: Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered Staff Nurses for all departments (including Operating-Room); 5-day wk; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Registered Nurses for 74-bed General Hospital, starting salary for nurses currently registered in Ontario $275 per mo. Full maintenance $50 per mo. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260, Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 50-bed hospital. Salary $270, 5-day wk., summer & winter sports area. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses. 40-hr. wk. effective January 1, 1960. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for modern 42-bed hospital. Starting salary: new graduates, $275; 1 or more year's experience, $285. Annual increments; shift differential bonus; Ontario registration necessary for maximum salaries. 40-hr. wk. Residence accommodation available. Apply to: Nursing Supervisor, General Hospital, P.O. Box 909, Sioux Lookout, Ont.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

TORONTO GENERAL HOSPITAL

requires

NURSING STAFF

Variety of Opportunities, Valuable Experience in this large teaching centre. Attractive Personnel Policies. Five Day Week.

The Toronto General Hospital has opened its new building which contains centralized Operating Rooms; Recovery Rooms; Surgical Supply Service; Obstetrics and Gynecology; Neurology and Neurosurgery; Admitting and Emergency; Rehabilitation and Physical Medicine; Urology and Ophthalmology.

For information write to:

Director of Nursing, Toronto General Hospital, Toronto 2, Ontario.

THE SARNIA GENERAL HOSPITAL

OFFERS EXCELLENT OPPORTUNITIES FOR

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

The hospital is modern, fully approved (J.C.A.H.) with plans for an expansion program to be completed over the next five years.

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

Salary Schedule:

for Registered Nurses — $255 per month to $313 per month.

for Certified Nursing Assistants — $175 per month to $209 per month.

Apply to:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

QUEBEC

Assistant Head Nurses; Afternoon Supervisor excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $260 per mo. in effect by February 1960, 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Board & accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron. King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

SASKATCHEWAN

Head Nurse for Operating Room in a modern 80-bed hospital. Basic salary $310 with recognition for P.G. courses, university training & for previous experience. 40-hr. wk., good personnel policies, residence available. Apply: Director of Nurses, Weyburn Union Hospital, Weyburn, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses for new 18-bed hospital with new nurses' residence opening May 1960. We have 4 Doctors on our Medical Staff also Canadian Mental Health Services & Canadian Arthritis & Rheumatism Services. 30 days annual vacation, this includes statutory holidays. Starting salary $260 per mo. which shall be increased in January 1960. Apply: John Uhryn, Administrator, Union Hospital, Davidson, Saskatchewan.

General Duty Nurses, combined Lab. - X-Ray Technician. Salary according to S.H.A. salary schedule & S.S.C.L.X.T. schedule. Apply to: The Matron, Bengough Union Hospital, Bengough, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn., O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Staff Nurses for 200-bed General Hospital; heart of Los Angeles cultural & educational center. **General Duty:** $335 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays 12 day sick leave. Cotton uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools. California license obtainable immediately. Promotions made from staff whenever feasible. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South, St. Louis Street, Los Angeles 23, California.

Registered Nurse for 20-bed General Hospital located near San Francisco. Salary: $320-$335 per mo. 40-hr., 5-day wk., rotating shifts. Vacation with pay. Meals & room at hospital reasonable. Apply: Administrator, P.O. Box B., Gustine, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

HOSPITAL COUNSELLOR (Nursing)

REQUIRED BY

SASK. DEPT. OF PUBLIC HEALTH

SALARY: **$364 - $443 per month**

REQUIREMENTS: Reg. N., preferably supplemented by courses in nursing administration and considerable experience in the supervision of nursing services, preferably in a public general hospital. Although headquarters for this position is Regina, the successful applicant will be required to travel throughout the province and will spend approximately 50 per cent of her time away from headquarters. (The appointee will review such aspects of nursing services as qualifications of personnel, methods and procedures, quality of services being provided and will provide consultant service to hospital authorities as required.)

BENEFITS: Three weeks holidays, three weeks accumulative sick leave allowance annually with pay, excellent pension and group life insurance plans and other benefits.

APPLICATIONS: Forms and further information available at Public Service Commission, Legislative Bldg., Regina, Sask. Applicants should refer to File No. c/c 6200. This competition closes as soon as a qualified applicant is obtained.

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Operating Room Supervisor for 230-bed progressive J C A H General Hospital in rapidly growing town of 40,000. Salary $4,700 - $6,000 pending professional background. 40-hr. wk., week-ends free; liberal policies. Fully accredited N L N school of nursing of 50 students; faculty status B.S., desired and/or postgraduate study required. Located 65-mi. from New York city in foot hills of Berkshires. Write: Mrs. Elsa L. Brown, Assistant administrator, Nursing, Danbury Hospital, Danbury, Connecticut.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation Highland Park, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 400-bed, non-sectarian General Hospital affiliated with Medical School. New salary rates $370-$400 days & $400-$430 afternoons & nights per mo., 40-hr. wk., comfortable, low cost living accommodation in attractive residence building. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th, Place, Chicago 8, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

General Staff & Operating Room Nurses for 88-bed modern JCAH General Hospital. Starting salary $300; $20 differential evening & night; $40 O.R. call, 40-hr. wk. Liberal personnel policies. College town 30,000; 85% sunshine belt, dry mild all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

TEAM NURSING IN THESE HOSPITALS!



Head Nurses • Assistant Head Nurses • Team Leaders

Qualified by professional training and personality to provide administrative guidance and high quality bedside care.

Salaries at the rate of $6,420 - $5,340 - $4,860 per year depending on experience and training. Annual increases. 40 hour week. Shift differential where applicable. 4 weeks vacation. 7 paid holidays. Laundry of uniforms. Social security plus non-contributory retirement plan.

General Duty Nurses at the rate of $4,440 per year.

Write to:

MINERS MEMORIAL HOSPITAL ASSOCIATION
BOX 61, WILLIAMSON, WEST VIRGINIA, U.S.A.

REGISTERED NURSES

SEQUOIA Hospital **in Redwood City, California, U.S.A. has openings for general duty, supervisory and head nurses.**

This is a 350-bed district hospital located on the Peninsula twenty-five miles south of San Francisco.

SALARY (REGISTERED NURSES:) To start *$360* per month with *$10* increases every six months to a maximum of *$400*. *$15* differential for 3-11 shift. *$10* differential for 11-7 and operating and delivery room services.

VACATIONS: After 1 year - 10 days (2 weeks)
After 2 years - 15 days (3 weeks)
After 3 years - 20 days (4 weeks)

Pension Plan (paid by employer) — Group Insurance

Credit Union **Social Security**

Affidavits of employment will be furnished to qualified applicants.

For further information, write *PERSONNEL OFFICE,*

Sequoia Hospital, Redwood City, California, U.S.A.

Staff Nurses (Intensive Care Unit) for real bedside nursing. Take advantage of this excellent opportunity to gain experience in the newest media of patient care. You will be trained at full salary to serve in St. Paul Hospital's second Intensive Care Unit. Openings for all shifts, excellent employee benefits. Inquire: Personnel Department, St. Paul Hospital, Dallas, Texas.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Registered Nurses, General Duty & Operating Room (All areas & shifts available) for 165-bed JCAH Hospital, new 50-bed addition to be opened in March. Starting salary $305 General Duty, $320 O.R. 40-hr. wk., 2-3 wk. paid vacation, sick leave, nurses' residence available at reasonable rates. Excellent shift differentials. Apply: Director of Nursing, Memorial Hospital, Cheyenne, Wyoming.

Positions open in all divisions of our nursing service. Transportation to the extent of $150., refunded after 1-yr. continuous service. Help offered in securing California registration. Apply: H. S. Hansen, Personnel Director, Saint Agnes Hospital, 530 W. Floradora Avenue, Fresno, 5, California.

Registered Nurses (Medical-Surgical O.R.) for modern accredited hospital. Generous personnel policies. Apply: Director of Nurses, De Paul Hospital, Cheyenne, Wyoming.

Supervisory or Staff Position; according to your qualifications. (Come to Sunny California). This 500-bed accredited teaching hospital offers unusual opportunities for growth. Excellent starting salary & increment program. Holidays — sick leave — vacations & Group Insurance. We feel sure we will be able to place you, we know you will like being associated with this modern progressive hospital that is located in the heart of the greater Los Angeles metropolitan area. Apply: Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for 278-bed fully accredited hospital with all services, incl. Starting salary $350-$375 per mo., ICU Retirement Plan, paid insurance, & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

ALBERTA

Instructor, Psychiatric Clinical (to teach affiliating students in 8-wk. program) 1500-bed active treatment hospital conducting an accredited school of nursing. Salary range $4,320 to $5,160 per annum, 40-hr. wk., civil service holiday, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply stating qualifications & experience to: Superintendent of Nurses, Provincial Mental Hospital, Department of Public Health, Ponoka, Alberta.

Clinical & Educational Coordinator (1), Medical & Surgical Clinical Instructors. For information please write to: Director of Nurses, School of Nursing, General Hospital, Edmonton, Alberta.

BRITISH COLUMBIA

Clinical Instructor in Surgical Nursing. Degree of diploma required & experience preferable. Salary $355 per mo., credit for past experience. Annual increment, cumulative sick leave, 28-days annual vacation, B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Clinical Instructress (with Degree or Certificate), **Operating Room Nurses** (Postgraduate Training), **General Duty Nurses** for 450-bed hospital, B.C. registration required. Salaries & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

Graduate Nurses (2). Salary: $285 per mo. Room, board & laundry: $40 per mo. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurses for new 63-bed accredited hospital 25-mi. east of Vancouver in Fraser Valley. R.N.A.B.C. contract in effect. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

General Duty Nurses (2) (Required June 1st.) Starting salary $285, personnel policies in accordance with R.N.A.B.C. recommendations. C.U. & C. Health Plan in operation. Room & board in comfortable nurses' residence $40. Situated on the Pacific Coast near several bathing beaches. Apply: Tofino General Hospital, Tofino, V.I., British Columbia.

General Duty Nurses for 40-bed hospital, salary $285 with increments for B.C. registered; $270 if not B.C. registered. Living quarters available. Apply: St. Martin's Hospital, Oliver, British Columbia.

MANITOBA

Matron (Immediately) Starting salary $300 per mo., **Registered Nurse** starting salary $290 per mo. Present hospital being enlarged & renovated & will be operating as a fully modern 15-bed hospital within a few weeks. Living in accommodation. For further information write or wire: Mrs. E. L. Johnson, Chairman, Arborg Memorial Hospital, Arborg, Manitoba.

Registered Nurse for 10-bed hospital. Salary: $280 per mo., less $30 per mo. full maintenance. Increments of $5.00 each 6-mo. Fare paid after 6-mo. employment. 21-day vacation with pay. Health plan benefits available. Apply: Dr. A. Marrack, Snow Lake, Man.

OPERATING ROOM SUPERVISOR

FOR 200-BED HOSPITAL

DUTIES TO INCLUDE ADMINISTRATION OF DEPARTMENT AND TEACHING OF THE STUDENTS DURING THEIR OPERATING ROOM EXPERIENCE.

POSTGRADUATE STUDY REQUIRED.

For details apply to:

DIRECTOR OF NURSING, GENERAL HOSPITAL, CORNWALL, ONTARIO

NURSES — *See the Capital of the United States,* WASHINGTON, D.C.



New, modern, air-conditioned - 300-bed general hospital situated 7 miles from Washington, D.C. Registered Nurses, Supervisors and Certified Nursing Assistants needed. Housing arrangements; good personnel policies under formulation. Salary ranges open.

Registered Nurses, $3,960 - $4,320; Supervisors, $4,840 - $5,400.

Applications being accepted now for positions in early Fall. Assistance will be given to obtain registration in the United States.

Join a *new* hospital — a challenging opportunity! Write for information:

DIRECTOR OF NURSING, THE FAIRFAX HOSPITAL,
1057 WEST BROAD STREET, FALLS CHURCH, VIRGINIA

RED CROSS OUTPOST HOSPITAL SERVICE

REQUIRES

ONTARIO PROVINCIAL SUPERVISOR

Applications are invited from Registered Nurses with University preparations in Public Health and experienced.

Salaries are in proportion to qualifications.

Pension Plan and other employee benefits.

Apply in writing to:

DIRECTOR, OUTPOST HOSPITAL DEPARTMENT
ONTARIO DIVISION,
THE CANADIAN RED CROSS SOCIETY
460 JARVIS STREET, TORONTO 5, ONTARIO.

NURSING OPPORTUNITIES

Completion of expansion program makes available opportunities for nursing appointments:

Instructors—Two
Preparation of at least one year Nursing Education desirable.

General duty nurses—for Operating Room, also Medical and Surgical Nursing.

Apply: Director of Nursing,
BROCKVILLE GENERAL HOSPITAL, BROCKVILLE, ONTARIO.

SCIENCE INSTRUCTOR

REQUIRED FOR

Approved School of Nursing with new 125-bed Residence & School

Accredited Hospital — 300-beds

on or before August 1st.

Apply: Director of Nursing,
ST. THOMAS-ELGIN GENERAL HOSPITAL,
ST. THOMAS, ONTARIO.

NOVA SCOTIA

Registered Nurses for 80-bed hospital, starting salary $220 with annual increments, living accommodation available. Apply: Director of Nursing, Highland View Hospital, Amherst, Nova Scotia.

ONTARIO

Director of Nursing for modern 100-bed non-teaching, General Hospital located in progressive town of 11,000 in beautiful Rideau Lakes region. 1-hr. drive to Capital city. Live in or out, pension plan, no construction problems. Salary open & dependent upon qualifications & experience. References required. Apply giving full particulars to: Administrator, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered Nurses & X-Ray Technician (Immediately) Salary; Nurses — $280 per mo. Technician — $275 per mo. Apply: Little Long Lac Hospital, Geraldton, Ontario.

Registered Nurses & Certified Nursing Assistants for a Medical Unit (non-Tuberculous), 5-day wk., 4-wk. annual vacation, pension plan. Residence accommodation available. Apply: Director of Nursing, Niagara Peninsula Sanatorium, St. Catharines, Ontario.

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $270, 40-hr. wk., 14-days sick leave, 1-mo. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Public Health Nurses (Kitchener Department of Health, September 1960). For further information write: Miss Olga Friesen, Department of Health, 9 Ahrens Street East, Kitchener, Ontario.

Nurses for Nurses' Technician Team (Intravenous & Intramuscular Therapy, Venepuncture etc.). 40-hr. wk., shift work. Good personnel policies. Apply: Assistant Superintendent, Ottawa Civic Hospital, Ottawa, Ontario.

SASKATCHEWAN

Registered Nurses (2), Practical Nurse (1) for 10-bed hospital situated in south central Saskatchewan 120-mi. south west of Regina. Pop. 600, (60% french & 40% english speaking), 2 churches, convent, public school, skating & curling rinks. Salaries offered: $270-$320 for R.N.'s & $165-$180 for P.N. Write or wire: L. Sylvestre, Secretary, Union Hospital, Willow Bunch, Saskatchewan.

Registered Nurses (2) Certified Nursing Assistants. Salary $280-$310 & $180-$210 respectively. 40-hr. wk., transportation allowance. Applications to: Matron, Gull Lake Union Hospital, Gull Lake, Saskatchewan.

CITY OF OTTAWA PUBLIC SCHOOL BOARD

SUPERVISOR OF NURSES REQUIRED

To supervise staff of 18 nurses, under direction of the School Medical Officer, on the Public School Health Service Staff.

The person selected will serve during the school year only. Initial salary will be commensurate with experience and qualifications, and there are annual increments to a maximum of $6,500. There are in operation a pension plan, a comprehensive group insurance plan, a plan of sick-leave with pay & a cumulative sick-leave & sick leave gratuity plan.

Applicants will be required to hold a degree of B.Sc. N. or equivalent, to have had experience in Public Health Work particularly with children, and to have had experience in training and supervision of other nurses.

Replies stating age, experience and qualifications should be addressed to:—

THE SECRETARY-TREASURER,
CITY OF OTTAWA PUBLIC SCHOOL BOARD,
330 GILMOUR STREET,
OTTAWA 4, ONTARIO.

REGISTERED NURSE INTERNSHIP

NEW YORK UNIVERSITY

Offers to registered nurses who meet admission requirements of the Dept. of Nurse Education, School of Education, a one-year Internship in Oncological Nursing at James Ewing Hospital of the Department of Hospitals, Memorial Center.

Experience in nursing care of the patient with cancer receiving therapy by surgery, radiation and chemotherapy; includes cancer research. Scholarships available. A stipend equivalent to base staff nurse salary, laundry and two meals a day are provided, also, assistance in securing desirable living facilities.

Classes are admitted in the Fall and Spring semesters. Applications for September, 1960 and the 1961 classes are now being accepted.

For further information write to:

NORMA F. OWENS, DIRECTOR INTERNSHIP IN ONCOLOGICAL NURSING, DEPT. OF NURSE EDUCATION, SCHOOL OF EDUCATION, NEW YORK UNIVERSITY, WASHINGTON SQUARE, NEW YORK 3, NEW YORK.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal

U.S.A.

General Duty Nurses (English Speaking) 500-bed General Hospital in sunny Southern California. $330-$375 base plus $33 shift differential upon registration. **Operation & Delivery Room Nurses** $340-$385 upon registration plus $33 shift differential. Employee health & pension plan. Generous holiday & vacation benefits. Nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

Registered Nurses for 90-bed accredited hospital. Top salary, excellent benefits, good personnel policies, opportunities for promotion. Apply: Administrator, Sidney A. Sumby Hospital, 234 Visger Road, River Rouge 18, Michigan.

Graduate Staff & Operating Room Nurses for 225-bed General Hospital, near New York City. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, New York.

Operating Room Supervisor for 88-bed modern JCAH General Hospital. Minimum salary $335 based on qualifications, $40 call pay. Liberal personnel policies. College town 30 000, 85°/ sunshine belt, dry mild all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

THE VANCOUVER GENERAL HOSPITAL

requires

PEDIATRIC, OPERATING ROOM & PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff. Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department, Vancouver General Hospital, Vancouver 9, British Columbia.

THE MONTREAL GENERAL HOSPITAL

MONTREAL

requires a

POSTGRADUATE CLINICAL INSTRUCTOR

Operating Room

For further information apply to:

THE DIRECTOR OF NURSING,
THE MONTREAL GENERAL HOSPITAL,
MONTREAL, QUEBEC

HAMILTON GENERAL HOSPITALS

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will have vacancies
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in the field of
SCIENCE AND NURSING
at the end of the school term

The school of nursing has a program of 2 years correlated theory and practice plus 1 year internship for approximately 300 students

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430-bed General Hospital, JCHA accreditated. All clinical areas. Salary $320. to $400. per month days; $340. to $420. per month evenings and nights; automatic annual increases; credit given for previous experience. 40-hour, 5-day week; paid overtime, holidays, vacation and sick leave. Excellent opportunities for promotion. Active orientation and in-service education program. Living quarters available if desired.

Write to: Director of Nursing,

THE CHARLES T. MILLER HOSPITAL, ST. PAUL 2, MINNESOTA



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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

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- STARTING SALARIES $376 WITHOUT EXPERIENCE, $395 WITH ONE YEAR PSYCHIATRIC NURSING
- STIMULATING AND CHALLENGING CAREERS
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- REGULAR SALARY INCREASES
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Write Mrs. Katharine Steele

DIRECTOR OF NURSING SERVICES, DEPARTMENT OF MENTAL HYGIENE
1320 KAY STREET, SACRAMENTO 14, CALIFORNIA

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PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

Apply to:

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Victorian Order of Nurses
for Canada
5 BLACKBURN AVENUE
Ottawa 2, Ont.

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required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 2; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

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GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

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WOODSTOCK GENERAL HOSPITAL
Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical, Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

REGISTERED NURSES
and
Certified Nursing Assistants
required by
TORONTO EAST GENERAL HOSPITAL
MODERN 750-BED HOSPITAL
RESIDENTIAL AREA
Good salaries and Personnel Policies
PENSION PLAN, 40-HOUR WEEK

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DIRECTOR OF NURSING
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COXWELL AT SAMMON AVENUE
TORONTO 6, ONTARIO.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

GENERAL DUTY NURSES

for 82-bed fully accredited General Hospital. Salary $275 - $315, 40-hour week, no split shifts. Living accommodation in modern nurses' residence and uniforms laundered for $8.00 - $12.00 per month.

Will refund cost of railway fare to Canora, after 6-mo. service.

Apply to:
Superintendent of Nursing,
CANORA UNION HOSPITAL,
CANORA, SASKATCHEWAN.

REGISTERED NURSES
required for
MENTAL HEALTH SERVICES
B.C. CIVIL SERVICE

Starting salary $270-$292 per month depending upon experience, rising to $325 per month. Applicants must be Canadian citizens or British subjects and registered, or eligible for registration in British Columbia.

For application forms apply IMMEDIATELY to the:
PERSONNEL OFFICER, B.C. CIVIL SERVICE
COMMISSION, ESSONDALE, B.C.
COMPETITION NO. 59:608

NURSING SUPERVISORS
required for
MENTAL HEALTH SERVICES,
ESSONDALE, PROVINCE OF BRITISH COLUMBIA.

Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:
THE PERSONNEL OFFICER, B.C. CIVIL SERVICE
COMMISSION, ESSONDALE, BRITISH COLUMBIA
IMMEDIATELY. COMPETITION NO. 59:152

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A new modern 300 bed unit
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An interesting variety of experiences
Good personnel policies
Salary allowance for experience and postgradwate courses.

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DIRECTOR OF NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

SUPERINTENDENT OF NURSES

FOR

CLEARWATER LAKE HOSPITAL

THE PAS, MANITOBA

Required May, 1960. Well equipped 160-bed hospital with general and tuberculosis patients. Salary range $355-$400 per month, commensurate with experience and qualifications. Good residence accommodation and excellent personnel policies. For information and application apply:

Director of Nursing Services:

SANATORIUM BOARD OF MANITOBA,

668 BANNATYNE AVENUE, WINNIPEG, MANITOBA.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN FUNDAMENTALS OF NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include: Clinical and classroom instruction in fundamentals of comprehensive patient care; integration of Introductory Pharmacology (solutions and dosage); instruction in an integrated course of Medical-Surgical Nursing.

Requirements: University preparation in Nursing Education.
Salary differential for degree.

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DIRECTOR, SCHOOL OF NURSING,

2240 KILDARE ROAD, WINDSOR, ONTARIO.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,

IROQUOIS FALLS, ONTARIO.

CLASSROOM & CLINICAL INSTRUCTORS

GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.

Partial fare refund after 1 yr. in service.

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DIRECTOR OF NURSING,

GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.



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Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

The phenomenon known as "growing pains" is not restricted to children. Schools of nursing have exhibited the symptoms — even nursing associations!

As HAZEL BERNICE KEELER, chairman of the national Committee on Nursing Education, reports on the various aspects of the work of her committee during this past biennium, there are many evidences of growing pains. She asks many serious questions that both deserve and require further study, locally as well as nationally.

A native of Saskatchewan and a graduate of the Vancouver General Hospital, Miss Keeler has had broad experience in many aspects of nursing education. Since 1950 the director of the School of Nursing, University of Saskatchewan, she started her career as obstetrical supervisor in a small hospital. Successively thereafter, she was a science instructor, a clinical instructor, principal of a school of nursing, university lecturer, provincial coordinator and adviser to schools of nursing, and in 1953 saw a cherished dream come true when the centralized lecture program became a reality in Saskatchewan. Despite the success of the latter program, reported in 1957 by Miss Lola Wilson in "The Story of the First Three Years," no similar pattern has evolved in any of the other provinces. They continue to rely heavily upon "part-time teachers" as Miss Keeler's editorial reveals.

* * *

To introduce those of you who are unfamiliar with Nova Scotia to the historical lore of that province, we are pleased to present the first of two articles written by PETER O'BRIEN of the Nova Scotia Publicity Bureau. This is the story of the province as a whole. Next month Halifax will be the centre of interest. We wish it were possible to reproduce in color photographs of some of the beautiful spots throughout the province. If you have never spent a leisurely holiday in Nova Scotia, you have missed a real pleasure.

* * *

As you review the tentative program for the biennial convention, you will become conscious of the disappearance of one of the familiar features of such programs for the past many years. It has been decided to eliminate the classical address that has been known since 1944 as the "Mary Agnes Snively Memorial Lecture." However, the founder of the Canadian Nurses' Association is not to be forgotten. The ceremonies that mark the introduction of the new honorary members of the CNA seemed to the Executive Committee a more appropriate occasion to pay tribute to that gallant and far-sighted lady.

* * *

In this issue you will find the Nomination Slate for the 1960-62 biennium. The brief "who's who" after each name will identify the various nurses who seek election.

* * *

Canada's newest university School of Nursing — that of New Brunswick — was opened to classes only last year. The director of the School and professor of nursing, KATHERINE MACLAGGAN, interprets the role of their program in the expanding nursing education developments in this Maritime province.

* * *

Primary emphasis in this issue is given to community aspects of nursing. Among other authors, DR. STANLEY GREENHILL shows us how and why the pattern and the needs have been changing in the past generation. MARY P. EDWARDS has described the program of service that has evolved in Saskatchewan.

* * *

The fillers about Nova Scotia were taken from Dorothy Duncan's *The Blue Nose — A Portrait of Nova Scotia.*

The Loyalist Church of St. Edward located in **Clementsport, N.S.** was consecrated in 1788. Its architecture is Norman and its doors have handmade hinges and nails. Plaster on the walls was made from burned clamshells and it remains too hard to pierce with a nail. — DOROTHY DUNCAN

Chebogue Point commands a wonderful view over the Atlantic and the Tusket Islands. Between here and **Yarmouth,** during certain weeks in summer, roadside banks are covered with blue lupin, spread from garden seed first brought from Holland. — DOROTHY DUNCAN


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Random Comments

Dear Editor:

You have no doubt noted the error on page 233 of the March issue in the article "Review of the Pilot Project." The first sentence which follows the guide questions should read: "The responses were most encouraging." I am sure the readers will probably sense this error when they read the sentence.

HELEN MUSSALLEM

¶ *We regret this error.* Ed.

Dear Editor:

During my past three years of training I have found *The Canadian Nurse* very informative and often invaluable.

I realize that the opinions expressed therein are not necessarily those of the Canadian Nurses' Association, but I would like to question two answers given in the "Objective Test of Fundamentals of Nursing" printed in the January, 1960 issue in the article "Test Construction in Nursing Education."

Question No. 4 reads: "Occupation and economic status of the patient must not affect the kind of care given by the nurse." The given answer was "False." This is exactly opposite to what I have been taught. I pledge myself to "practise my profession faithfully" — to all — not just those fortunate enough to be in the "upper bracket." I hope this is a misprint or misunderstanding on my part.

Question No. 39 reads as follows: "Exclusively the doctor's responsibility" — Answer — Prognosis! The doctor sets down the diagnosis and prescribes the treatment. God, the nurse, and the patient himself hold his prognosis. This seemed to be a very vague question.

A nation-wide accepted set of registration papers would be a real step forward for Canadian nurses, and I do hope that someday, in the not too distant future, it will be a reality.

Thank you very much for the many interesting and helpful articles in your magazine. I am looking forward to the day when I shall have my own copy to read and keep!

S. O'D., New Brunswick

¶*How do other readers feel about these test questions?* Ed.

Dear Editor:

The February *Canadian Nurse* arrived, I

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glanced at the table of contents and turned to page 141 "Patient Care at Home." After reading the article twice with great interest I found it hard to realize that no mention was made of the home care plan which has been in operation for about eight or ten years at the Reddy Memorial Hospital.

While most nurses in the Montreal area are aware of this service I feel sure the majority in other parts of Canada might not be so well informed.

L. M., Quebec

¶*A comprehensive article on this subject appeared in The Canadian Nurse, Vol. 54:773.* Ed.

Dear Editor:

A woman I know told me that her sister, facing a second operation for cancer, did not dread the operation nearly as much as the agony of having a catheter passed.

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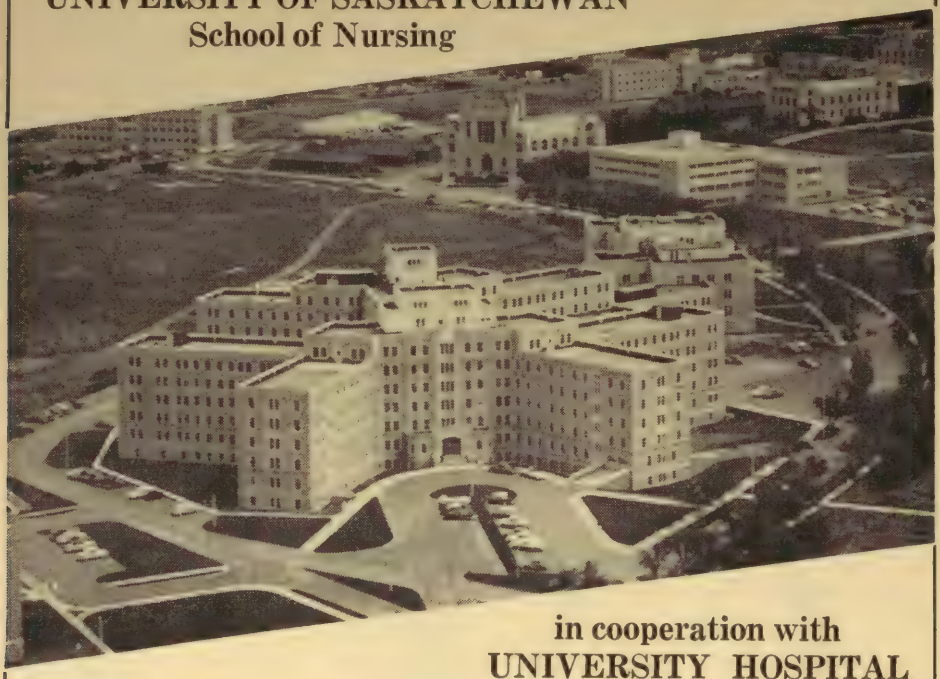


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*Weinstein, J. J. Bowel Preparation for Anosigmoidoscopy with a Hydrogogue Enema. To be published.

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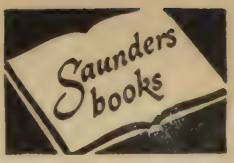
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 5

MONTREAL, MAY 1960

UNCOVERING SOME FACTS

A VISITOR FROM THE UNITED STATES once said that she preferred to visit Canada in the winter because Canadians were more normal in the cold weather! Since this past winter, as well as that of last year, brought more than the usual quota of cold and stormy weather to most parts of Canada, one might conclude that nursing activities in this biennium have been even more normal than usual. In my part of the West we had a particularly early start this year since it turned cold in the middle of August!

I am not sure that there is a positive correlation between climate and the activities of the national and the provincial nursing education committees but ample evidence has accumulated from reports of meetings and group projects to justify such a conclusion.

The national Nursing Education Committee started the biennium with high hopes that much could be accomplished. Three major projects were selected. After all, we said, two years is a long time. Although we found out quite early that the segment of time available in each year in which to accomplish a task is startingly short, we do have something to show for our efforts.

One of the projects we chose was to assess the present situation regarding instructional staff in our basic schools of nursing. To this end we conducted a fact-finding survey. We received returns from 171 schools. The results obtained were both interesting



Esquire Photo, Saskatoon

HAZEL B. KEELER

and informative and in this brief editorial I will share a few with you.

Did you know that up to one-third of the teaching load in our schools of nursing is carried by part-time teachers, both nurses and non-nurses? In three provinces one quarter or more of the teaching load is carried by part-time nurse teachers. In two provinces there are as many part-time nurse teachers as there are full-time nurse teachers. In five provinces there are *more* part-time nurse teachers than full-time. The questions we asked after looking at this piece of information were logical ones. Is it an educationally sound policy to utilize such a high proportion of part-time teachers? Is it possible to achieve the desired objectives in basic nursing education when a large number of part-time people are contributing to the teaching program?

Did you know that there are 1446 full-time nurse teachers employed in our schools of nursing? Of this number 31% have no special preparation for teaching, 42% have a university diploma or certificate, and 22% have a Bachelor's degree. Fifty-four or 3% of the nurse teachers in Canada have their Master's degree. One question that might be asked is: what should be considered minimum preparation for teaching? The survey also revealed that there is considerable difficulty being experienced by our schools in filling the various teaching positions. Seventy vacancies were reported. A question that suggests itself is: what are we doing to ensure an adequate number of qualified instructors?

It was interesting to learn that 26% of our schools have a total enrolment of fifty students or less while 64% have a total enrolment of a hundred or less. A question that might be raised is: should centralization of teaching programs be considered in order to make better use of our available teaching force?

Two trends were quite noticeable. The shift to one class a year appears to be definitely established. Only 45 of the 171 schools continue to admit two classes. Affiliation patterns also appear to be changing. The most common clinical experience provided by affiliation is in psychiatry and 27% of the students are now receiving this experience. Less than half of the schools of nursing provide tuberculosis experience for their students. Other affiliations include pediatrics (55 schools) and public health nursing (46 schools). This prompts us to ask: should we aim at psychiatric nursing experience for all students? Should some other experience than tuberculosis be arranged? Should we be thinking about geriatric or small hospital affiliation?

Our second project was to arrange a conference on curriculum development which we held in November, 1959. We felt that this was a timely thing to do because of the considerable activity in curriculum revision in most of the provinces. We planned to produce a guide for curriculum development which would be useful to committees working in this area. We were able to prepare a tentative guide which at present is in the hands of the provincial education committees for their study. It is hoped that constructive suggestions for change and comments on its usefulness will be brought to the attention of the incoming national committee. The production of a worthwhile curriculum development guide will obviously take more than one biennium for completion.

Our curriculum conference was interesting, informative and, to some of the participants, a bit disturbing. It is not easy to accept an approach to curriculum study that differs markedly from a familiar and comfortable one. The aim of our conference was to help us change our orientation from a procedure and disease-centred curriculum to a patient-centred curriculum in order to bring it more in line with the present philosophy of total health care. It was a bit like being pulled up by the roots, and it hurt! However, we will be none the worse for having had this experience and I will venture to say that "back home" the shift will slowly but surely get started.

HAZEL B. KEELER
Third Vice President
Canadian Nurses' Association

Procrastination is the art of keeping up with yesterday. — MARQUIS

OUR CHANGING SOCIETY

STANLEY GREENHILL, M.D., D.P.H., F.A.C.P.

Changes in Canadian society are not only numerous but have taken place rapidly. These two factors influence every aspect of our life. Medicine and nursing are affected by societal changes, and themselves effect change in society.

OFFICIAL HEALTH REPORTS continue to show an improvement in Canada's health. Canadians, meanwhile, continue to fill more and more hospital beds, and to request bigger and better government-subsidized health schemes. This discrepancy between the statistical indices of health, and the individual's *feeling* of health is of prime importance to all members of the medical and nursing professions.

To ignore these pressures, or even worse, to remain ignorant of them, will not increase our competence to deal with them. It is to be remembered that medical care through government agencies is the rule rather than the exception for the majority of the world's population today. No matter what our reactions are to this world-wide trend, it will not be stopped by pretending that it does not exist.

To try to cover such an important topic in a short article is presumptuous. Instead, an attempt will be made to outline a few of the more dramatic changes occurring in our society — changes that will necessitate a revision in our thinking and approach to the whole problem of ill-health and sickness in Canada.

Population

If Canadians have any faults, sterility is certainly not one of them! In the past 20 years or so this country has almost doubled its population. In 1931 our population was officially estimated at 10.3 millions, in 1951 it was 14 millions, now it is over 17 millions. Most of this is due to natural increase; only about 30 per cent can be attributed to postwar immigration.

Such a rapid increase in population has naturally produced sociological pressures. Fortunately, for this country, there is still plenty of empty space. Unfortunately, there would appear to be little desire on the part of people to take advantage of it. Since 1950, 95 per cent of this increase in population has occurred in our metropolitan areas. The vast urban conglomerations possess many of the characteristics that we associate with a neoplastic growth.

In spite of the town planners, the urban areas continue to grow and engulf adjacent rural areas. In no time, these rural areas become the vast sprawling, conforming suburbias of the modern city. This trek to the city is accompanied by an evacuation from the rural areas. In Alberta, between 1951 and 1956, the increase in the urban population was 41 per cent while the loss from the rural areas was 5 per cent. Increase in the population in the city of Calgary was 41 per cent; increase in the population in the fringe areas of that city was 61 per cent. In Edmonton, similar values could be seen: 41 per cent increase in the city, 77 per cent increase in the fringe areas.

Change in Age Composition

Not only is the rate of growth and the distribution of our population showing remarkable changes, but one can detect important changes in its age composition also. Though we pride ourselves on belonging to a young nation, the actual truth of the matter is that we are an aging nation. The median age in Canada in 1900 was 23 years, in 1930 it was 26½ years, and in 1950 it was 30 years.

To confuse the picture a bit more, it must be mentioned that Canada's population is being made up more and more of the young and the old. This apparent paradox can be understood when it is remembered that in the "hungry thirties" the birth rate fell, but during the war and since, Canada has manifested a baby boom. Our birth rate of 28.6 in 1957 was one of the

Dr. Greenhill is Professor of Preventive Medicine, University of Alberta, Edmonton. This address was presented at the 1959 annual convention of the AARN.

highest in the world. It did not drop when hostilities ceased. The result has been that between 1951 and 1956 the number of those below the age of 15 increased by 23 per cent, those above the age of 65 by 14½ per cent. There was only a 6.7 per cent increase in those between 15 and 24 years of age. It looks as though Canada is now a land of opportunity for pediatricians, geriatricians, and obstetricians!

Life Expectancy

These few comments on the age composition of our population lead naturally to some remarks on our increasing life expectancy. These figures refer to the *expectation of life at birth.* If this is remembered, then it is undoubtedly true that a male born today will probably live 70 years. If he had been born in 1860, he would have likely only reached 40 years, due to the hazards surrounding the first year of life a century ago. Theoretically the expectation of life is greatest at the time of birth. In actual fact, the expectation of life in adolescence is somewhat greater owing to survival through the hazardous first year of life.

We can, therefore, rejoice in the fact that our children have a very much greater likelihood of attaining three score years and ten. This can be regarded as a credit side of the life expectancy tables. However, the middle-aged male has not much cause for rejoicing. The difference between the expectation of life at the age of 50 now is very little different from what it was in 1860. In other words, the mortality risks at the age of 50 to 55 are pretty much the same today as they were over 100 years ago.

Death Rates

No medical research worker has yet discovered the elixir of life. We are still as prone to the diseases of old age and attrition as were the Pharaohs of ancient Egypt. But if we are continuing to die, the reasons why we die are fewer in number than they were 100 years ago, and our death rate is lower. In 1921 the death rate was 11.6, by 1957 it had dropped to 8.7, one of the lowest death rates in the world. This fall in death rate is regarded as an index of the improved health of our population. It is, however, quite presumptuous of our professions to take credit for this improvement.

Perusal of any mortality tables, going back over the years, provides clear-cut statistical evidence indicating that this decrease in the death rate began to occur long before the advent of so-called "scientific medicine" and the widespread use of antibacterial drugs. The mortality caused by tuberculosis had dropped from a high point of 500 per 100,000 in 1845 to 50 in 1945. That is a ten-fold decrease in mortality rate. Yet no drug therapy was available during that period. Tuberculosis is but one example. Many other infections show the same decrease in incidence and mortality.

The decrease in death rates is a much more accurate reflection of improved living standards than of medical advances. In fact, the fall in the death rate figures parallels legislative demands for pure food, pure water, pure air and better living conditions. The fall began to occur long before vaccination or immunization techniques were known or practised. Most people now die from four main causes. Commonest by far are the cardiovascular lesions, amounting to about 60 per cent; cancer is the next most popular cause of death, accounting for 16 per cent; third on the list, at 7 per cent, is accidents; and fourth, at 5 per cent, is diseases of the respiratory system. It is both humiliating and depressing to remember that 11 per cent of all deaths occur in children who have not lived to one year of age.

Changing Pattern of Disease

It is a comparatively easy matter to obtain figures relating to mortality. It is an entirely different matter to try to obtain figures relating to morbidity. But enough data is available to substantiate the clinical impression that the pattern of disease is changing rapidly, and that more and more people, in spite of our statistical indices of improving good health, are, in actual fact, suffering from feelings of "dis-ease." More and more people are visiting doctors with symptom-complexes that defy pathological diagnosis. To supplement these, the incidence of such modern disorders as the arthritides, peptic ulcer, asthma, headache, dyspepsia, hypertension, and coronary insufficiency make up an in-

creasingly larger portion of the average physician's patient load. These diseases are not lethal but they are disturbing and incapacitating, and they lead to impaired efficiency at work and at home.

Present-day rigid concepts of disease causation cannot explain this mass of irreducible sickness that still remains with us. The concept of a specific etiology for a specific disease entity dates back to the great days of the German tissue pathologists and the French and German bacteriologists. This concept enabled medical research to make remarkable headway in its study of the causation of disease. However, with the great upsurge of disease entities of the type just mentioned this concept is now outmoded.

All of us will have to get used to the idea of thinking of multiple etiologies contributing to complex disease entities. To search for the cause of cancer, arteriosclerosis, mental disorder, and so on, will be fruitless. Disease states are not the direct result of a single determining factor, but the outcome of a variety of circumstances — circumstances to be found not only in the body, but also in the psychosocial environment. The research worker of the future, seeking to elucidate our modern day syndromes of "dis-ease" will have to be an individual of wide experience and broad background. He must be an individual able to integrate data from many disciplines and from disciplines not usually thought of as "medical."

Today's Patient and His Disease

The vast majority of patients come from urban centres. Many will be skilled tradesmen or office workers. A minority will belong to the professions. A smaller number still will be executives.

The average patient will be a well-educated individual with about 10 to 12 years of schooling. There is a four-to-one chance that he will be employed by somebody else, and therefore dependent upon that person for his continued livelihood. His wife will have borne him 2.6 children between her 22nd and 26th years of life. In order to help out with the family's indebtedness, the wife will undoubtedly have taken on some part-time or full-time work. In 1955, 25 per cent of Canada's labor force was female. About 40 per cent of these women were married, and most of them were in the 25-34-year-old age group. This family will be living in a three-bedroom bungalow, probably with a two-car garage. The house will not be their permanent home, since about 10 to 20 per cent of families change their residence annually. Nor will it be large enough for them to accommodate an influx of relatives. The arrival of guests will produce considerable disruption of household routine. The house will not be paid for, nor will the car and most of the electrical home appliances.

As far as making provision for medical care is concerned the typical family will have some type of hospitalization. A period in hospital may produce no financial strain. Medical and hospital coverage may more than compensate for medical and hospital expenses. Sickness benefits provided by the employer will make any period of illness relatively painless. About 86 per cent of the general population have some type of medical care coverage.

How different from 30 to 40 years ago! It sounds like a veritable utopia. Yet something must be amiss to judge by the line-up for hospital admission or the full appointment books of practising physicians.

No mention has been made of the cultural vacuum in which this young couple live, nor of the stresses, strains and frustrations that the husband experiences at his place of work. Promotion often is not based upon ability, but upon seniority. Maintenance of job and position is dependent upon conforming to the habits and customs of the organization that employs him.

The wife is hemmed in by the strict circumscribed ritual and taboos appropriate to the neighborhood. This neighborhood has not yet developed into a true community. It is still a "housing development." Social and other activities are still centred in the well-established districts. The neighbors are not yet neighbors but social rivals! The daily schedule is determined by school, office and transportation deadlines. Everything runs to a timetable.

This frantic search for security, a home, a family and financial success is but a manifestation of feelings of in-

security. Insecurity arises not only from the work situation but from some of the social factors already mentioned. International tensions add their quota of anxiety and uneasiness. This rigidity and conformity imposed by the mores of society produces loss of resilience and adaptability. Is it any wonder then that today's young people are subject to a variety of feelings of discomfort often interpreted as manifestations of ill health!

Both husband and wife regard illness as the major obstacle in reaching Utopia — a debt-free never-never-land. With their vague distresses, they visit a physician who has 19th century theories of disease causation. The physician may feel frustrated and incompetent in the face of these 20th century maladies. Because of medical attitudes ill-suited to the modern world he may doubt his diagnostic skill. The causative agents of his patient's illness cannot be found in a test-tube or under a microscope.

Changing Concepts of Etiology

Of course, the etiological agent will never be found. The causative agent is not single. The factors productive of feelings of disease are to be found as frequently outside of the body as in it — the "pathology" may be the man's place of work, his social milieu, the home environment, the marital situation, the parents and in-laws, or the anxieties and distresses generated by reading daily headlines or health hints! Medicine will have to broaden its concepts, disciplines and attitudes if it is to satisfy today's patient.

"The only safety for the years ahead lies in a professional training, sufficiently broad and flexible, so that the individual can survive the ups and downs and adapt himself to changing situations."* One of the manifestations of this unwillingness to change our approach and attitudes to the problems of sickness and disease can perhaps be best described as "the retreat from the patient."

The "Retreat from the Patient"

The nursing profession manifests this retreat from the patient in several ways. The trend in modern hospital architecture and design is to create more and more physical barriers between the nurse and the bed-bound patient. The term "nursing station" has a depressing similarity to the term "battle station." The nurse with her battery of flashing lights, microphones, and intercoms ensconced behind a glass-partitioned desk removed from her patient is reminiscent of a gunnery officer at his control station firing at an unseen foe! The nurse in white is still the symbol of understanding, sympathy and comfort to those who are sick or in pain, yet more and more these attributes are being usurped by girls in uniforms other than white.

The role of the registered nurse has changed markedly in recent years. No longer does she nurture or minister. Instead she administers or supervises. This change in her traditional role may well be due to unconscious feelings of inadequacy when faced with that most complex of beings — the modern patient in a hospital bed.

Conclusion

This has been a cursory review of some of the significant changes observable in our society. Undoubtedly these changes fascinate sociologists, intrigue economists, and challenge political leaders, but to the medical and nursing professions they are a matter of concern. Whether such concern is justified has been discussed. It has been suggested that our 19th century concepts of disease do not apply to many of our 20th century maladies. The old order changeth. The concept of multiple causality must replace the long respected "one cause, one disease" theory. Without such a change in thinking the complexities of today's illnesses will continue to disturb us and to reduce our effectiveness with patients.

If we accept this change in approach to disease causation then we must also change our long-held attitudes to "diagnosis." Diagnosis must become as comprehensive as the newer concepts of etiology. Instead of diagnosis being an indelible tag permanently attached to the patient, it should be a label — a label delineating the roles played by disease, emotion and social environ-

*Gairdner, J. W. Quoted in "Some Things Worth Knowing," by S. Chase. Harper Press. 1958. p.10.

ment, a label easily removed or changed as circumstances demand.

Acceptance of such concepts and ideas by the medical and nursing profession would demonstrate their awareness and sensitivity to present social changes. Application of them will enable medicine to maintain its prestige, status, and freedom to practise in this changing society of ours.

Public Relations in Public Health

Hans S. Falck

What are the aims of public health? Who sets them? How are they achieved? One thing is certain, in a democracy "public health cannot be legislated."

As a close neighbor I have been impressed and somewhat envious of the progressive ideas and programs that characterize the Canadian view of the citizen's responsibilities to his fellow men. Good intentions are only part of the effort and the enlightenment necessary to develop progressive social legislation. Your excellent child welfare programs, to cite only one example, attest to the willingness of your national community to nourish and preserve those who give meaning to our lives today, tomorrow and in the days to come. Your liberal immigration laws — the most liberal on our continent — are looked upon with admiration by many of us to the south of your border. Indeed, Canada can speak proudly of its good intentions as well as of its actions toward the goal that all mankind seeks — the constant betterment of man in his community.

Every social service, be it public or private, renders itself accountable for its activities, both in the qualitative and quantitative sense. Whether social services are financed and otherwise supported by tax monies, Community Chests or United Funds, or whether donations are made by individuals and organizations directly, there is provision made for formal accountability.

We are accustomed to think of accountability in the financial sense. How have funds been spent? For what purpose? How much is spent on salaries? How many people have been served, that is, what has been the *per capita* cost in relation to those served? Have funds been disbursed for the precise purpose intended by the income source? Nevertheless we are not satisfied that such accountability can also *interpret* our services. Figures have limits. While they tell a story, *what* they tell is limited, not very dramatic and difficult for the general public to understand. Formal accountability, therefore, is insufficient if we desire also to *educate*. Even the crudest kind of interpretation — the proverbial wheel-chair ridden, handicapped child on a poster speaks something to the public that numbers rarely, if ever, do.

Now we are making judgments. We feel that the heartstring-pulling poster is crude and insufficient; that it may be dramatic but it does not really inform in any intelligent sense. It may bring in dollars, but we have interests beyond fund-raising. We shall therefore, make another assumption. We shall hypothesize that the maintenance of good health, physical and mental, must be interpreted as part of the professional services that all of us render. In this connection we are primarily interested in prevention of illness since, at least some of the time, the acutely ill person and his relatives are aware of the need for treatment.

The ill or severely disturbed person may feel enough discomfort and pain to be motivated to seek help. While there are those who will seek assistance

Mr. Falck is assistant professor of social work at the School of Social Work, The University of Buffalo, Buffalo, N.Y.

reluctantly even when acutely ill, the general tendency is to enlist our aid when it is needed. However, it does not necessarily follow that a large part of the public will seek to maintain its health by regular check-ups — medical, dental etc. We face this problem primarily in relation to physical health. The proverbial "apple a day that keeps the doctor away" needs to be eaten just as often to keep the caseworker and psychiatrist away. Prevention of illness is only one reason why we, as professional personnel in the field of physical and mental health, are called on to redouble our efforts in interpreting our services.

A second reason stems from the fact that in a democratic society people who pay for services through the tax dollar are making services available to *themselves*. They have the right to know what they are getting for their money as well as what further services they may need. It is all too easy for the public to think that professional persons make services available simply because they are close at hand. We render the services but only in view of our professional and technical knowledge and skill. The availability of the service rests ultimately with the community. It pays the bills and determines policy — either through its elected representatives or through boards of directors in the case of voluntary agencies. This means that the ultimate responsibility for what a community can afford for itself does not rest with us but with the citizenry. It can be no other way in our kind of society. If the people as a whole want the service we are willing, even eager and enthusiastic to use the very best within us to accede. It is also on this basis that we educate and interpret in the most effective manner possible. We may persuade, plead, implore and guide, but we cannot really force.

What can we do? Public relations or the interpretation of our functions potential and actual, should be directed toward at least two audiences: the community and the individual patient.

The Community

We are living in a day in which advertising plays a large role in selling commercial products. People are sometimes torn between their admiration for the cleverness with which advertisers "reach them" and rebellion against the manipulation of their patience and their nerves. There was a time in the history of advertising when it was thought that all one needed to do was to tell the customer about the product. Advertisers felt that it was the merchandise itself that was important. A careful look at television commercials reveals that the product is closely dependent upon something else — *you*.

Some advertisements question and others support your sense of masculinity or femininity. "If you want to be a *man*," the ad says in effect, "buy this . . ." Or, if you are a *woman* and want to be an effective one, you must make yourself attractive to the men in your life. This is followed by the introduction of a new lipstick or powder. This is not to suggest that we should take such an approach. What we can learn from this is that true public relations must stimulate something in the listener that is an important part of him. Something within him must be activated that is so *very* important to him that he will tell others about it. This is why the so-called heartstring appeal has been very successful in raising money. Who does not feel sorry for a child in a wheel-chair? Whose sense of sympathy and even guilt is not stimulated when he is approached by an appeal for funds to fight cancer, when a neighbor, friend or relative has been stricken or perhaps died? The viewer or listener must become involved, intellectually and emotionally, if he is to absorb the idea we are trying to convey.

There is no flamboyant short-cut to public relations or interpretation in relation to the community. Tax-supported organizations as well as privately supported services need to give some real thought to the possibility of broadening and enlarging very considerably the base of community participation in their affairs. Too many professional men and women act as if all that is necessary is to see patients and "cases." Enlist your leadership people first. Perhaps you want a Citizen's Committee for Public Health. With proper guidance from you it could serve with great value. Settlement houses, for example, have used this technique for many years on be-

half of better housing and police coverage for neighborhoods with high crime rates. The people in Little Rock, Arkansas and the White Citizens Councils in the southern United States have, unfortunately, had great success with these techniques. Let people in on your problems. Ask for advice, for ideas, for opinions. Share your goals and hopes with the citizens in your area. After all they are the sponsors of the services you render.

Another approach might be made through existing organizations. There is a national women's organization in the United States, whose local chapter in a large city has supplied volunteer services for many years to a group working with retarded children. These ladies do everything from mailing literature to driving children to and from their homes. At the same time they are learning about disease, human need and suffering. The message the agency has to tell has not been lost on them. They in turn have been most effective in telling the story of retardation. They tell their friends and neighbors with conviction because they themselves are emotionally involved. And yet, the strictly professional domain has been reserved, as it always must be, for the professional people.

By such an approach an organization can tell its story through direct, personal involvement of individuals in the community. The results *are* slow in coming, partially because you have to start on a small scale and gradually widen your activities. It has been proven, however, that results are more lasting and community involvement more effective than a superficial, propagandistic approach can ever achieve. People will tell your story when they understand it.

One of the major developments in the history of ideas in Canada and the United States, is *egalitarianism.* One of the connotations of this word is, that neither here nor in my country does an intelligentsia exist in the class sense. There is no political or social movement that rests primarily upon the fact that its members are university graduates. This fact places the professional, university-educated person in the position where his function and usefulness is substantially limited to areas of professional technical participation. The minute that you and I leave our offices or the nurse takes off her uniform, we are ordinary citizens. Perhaps we may have special responsibilities to extend our job-connected social convictions into our private lives, but we have no special privileges that would set us aside on account of education, or prestige derived threfrom. In other words, we are held to be specific in our professional functions. What are the implications of this characterization of the professional person's social role?

The major one is that the citizenry and its representatives have a far greater opportunity for the kind of decision-making that is typical of agencies and clinics in health and mental health than it would have if our social role as professionals were different. Every tax-supported service is responsible, directly or indirectly, to some person or group who makes policy decisions.

You may ask, "What do citizens' groups or politically appointed citizens know about what I am doing?" While the question is legitimate, so is the answer: "Usually nothing, until you and I educate them and guide them so that they *will* know." Your citizens need not know how to pull a tooth, operate for appendicitis, nurse patients or check a piece of property to meet sanitary standards. We *can* educate them to the need for service, for better public health, for greater financing, without attempting to reach decisions which are theirs to make.

If we want better facilities, more service and better public understanding of health needs, we must, in addition to community groups, work with our boards and legislative committees. The important word is "with," not "at them" nor "for them." When properly involved and educated, these people generally can make decisions and make them intelligently. Every meeting with a city or town council, with boards of supervisors or with local and provincial legislators should have some provision for educating them to the needs of people. The process is slow, even cumbersome, but you will find that in the long run it is worth the investment of time and energy.

Health is primarily the responsibili-

ty of the community and the people who represent it. We as professionals are concerned, too but we must be careful not to assume all of the responsibility. If we do so it will be left with us. This would be neither in our interest nor to the community's ultimate welfare.

The Patient

The second possibility for public relations lies within the grasp of every one of us. It is the relationships between each of us and our patients.

There are few relationships between people that are more important to the individual than those between nurse and patient, between physician and patient. Many patients pin their hopes on them. They hang on each word that is spoken, think about them, interpret them, construe and misconstrue them, too. The influence of a nurse or a physician is enormous. Professor Talcott Parsons of Harvard University has said:

> . . . it should be noted that the burdens the physician asks his patients and their families to assume on his advice are often very severe. They include suffering — "You have to get worse before you can get better" as in the case of a major surgical operation; risk of death; permanent or lengthy disablement; severe financial costs, and various others.

It is no doubt true that most practitioners in the helping professions practice their art with a high degree of competence and deep interest. In *this* context there is, nonetheless, a difference in the attitudes of persons who state that they *practice* medicine, nursing, dentistry or social work and others who think of themselves as *curing* and *helping* patients. It is not that the former fail to help, but that the second group is aware that *people* are being treated—people who have unique personalities, distinct needs, likes and dislikes and who, in their disablement, are seeking along with physical care some recognition that they also have a psyche. There is no illness that is physical only. Every illness has emotional overtones, to say nothing of a variety of psychosomatic syndromes.

The interpretation of your therapeutic function then — whether this is to gain more community support, or whether you are aiming to improve on the preventive medical or public health aspect of your community — depends on whether or not at the most direct level of service to the patient, something exists that enables you to do more than, to put it crudely, "push pills."

The education of the patient-public depends on the constant development of the kinds of relationships that result in the opportunity to interpret our services. If we insist on appearing as authoritarian experts, our patients and clients may do what we order them to do but it is unlikely that many will do very much on their own to maintain and improve their health. To a considerable degree we wish to make ourselves unnecessary to our clientele. This would seem to mean that they should assume more and more responsibility for the care of their routine needs. Authoritarian relationships do not free — they shackle. They shackle in such a way that nobody gains at all. They make patients helpless, afraid, looking to you for miracles that you cannot perform. They make your life more difficult because you have a harder job to educate your various publics. In short, such relationships fail to involve the patient-community where and when involvement is needed most.

Community education on behalf of public health services has potentially powerful benefits, provided sufficient time and patience are invested. Such education can raise the level of service. It can result in expansion and in better financing. The prime demand would seem to be that, as part of the daily work, the general community, policy-making bodies and the patient should be afforded the opportunity to know about and to participate in their own affairs. To paraphrase the motto of a well known publication: "A well-educated public is our greatest support." The essence of our thinking then is that "public health cannot be legislated." This being true community involvement must be developed by positive relationships between public health personnel and the public. Such relationships are best achieved when they are fostered the whole year around. Thus, people will learn slowly that *their interest is at stake in the work that you do.*

Public Health Nursing in Saskatchewan

MARY P. EDWARDS, B.N.

Keeping the public healthy or guiding its members back to health requires a high degree of governmental organization.

Saskatchewan was created a province in 1905. Its first Public Health Act was passed in 1909, establishing a bureau of public health. The department of public health was created in 1923 and the division of public health nursing was formed in 1928.

The province has an area of 251,700 square miles extending 761 miles from the southern to the northern border with a 393 mile base along the Canada-United States boundary. The 1956 official census records a total provincial population of 880,665 with only 12,427 living in the northern half of the province. The southern half has 10 cities. The two largest, Regina and Saskatoon, comprise approximately 20 per cent of the 1958 provincial population, and administer individual health departments. Two of the cities included in health region programs have populations of 31,800 and 22,000. The remaining six vary between 5,400 and 10,612 citizens. In 1958 there were 104 towns and 371 villages.

In 1956, 41 per cent of the provincial population and 58.3 per cent of the people served by provincial public health nurses lived on farms. The number of people living in urban communities is increasing steadily due to an increase in mines, oil fields, manufacturing, construction, forestry and other non-farming activities.

Structure of the Division

The public health nursing division of the Saskatchewan department of public health is part of the regional health services branch. This division has a director and two nursing consultants. Originally, it was directly responsible for public health nursing services in the entire province, with the exception of larger urban centres and the Indian Health Service.

Miss Edwards is director of the Division of Public Health Nursing, Department of Public Health, Regina, Sask.

Organization of health regions and the northern health district placed public health nurses under the direction of a local medical health officer and a local nursing supervisor. The director of the division remains largely responsible for the public health nursing program and policy. One unorganized area, where limited public health nursing service is provided by four nurses, remains under the direct supervision of the nursing division. It is expected that this area will be organized into a health region soon.

The southern half of Saskatchewan, with the exception of the cities of Regina and Saskatoon, has been divided into 12 health regions. Eleven of these are organized and each is directed by a regional medical health officer. Public health nursing is carried out through a regional nursing supervisor, her assistant and a staff of public health nurses in the approximate ratio of 1: 5000 population. The regional nursing supervisor is directly responsible to the regional medical health officer who, in turn, is responsible to the director of the regional health services branch.

The public health program of the sparsely populated northern half of Saskatchewan, known as the Northern Health District, is directed by a medical health officer. Public health nursing functions are carried out by a nursing supervisor and a staff of six nurses. Four of the nurses are midwives stationed in outpost hospitals and they perform a dual role.

The division of public health nursing has direct contact with the regional medical health officers and the regional nursing supervisors of the whole province. At the same time it keeps the director of regional health services informed.

Functions

1. Consultative service to the director

of regional services; assistance with policy-making and planning.

2. Advisory and consultative services to health regions.

3. Selection and placement of public health nursing personnel in order that qualified individuals are available with the necessary equipment to do the work anticipated and at hand.

4. Direct supervision of nursing services in areas not yet organized into health regions.

5. Inservice education of supervisors and nursing staff in health regions.

6. Keeping staff informed of new concepts, methods or needs.

7. Development in the nursing staff of a spirit of devotion and unity of purpose.

8. Studying personnel policies and work conditions of other public health agencies and other nursing fields in relation to those in effect in this department.

9. Construction and revision of records and reports, as necessary, for efficient operation of nursing within the regional and district program structure.

10. Estimation and planning of the budget for the public health nursing division.

11. Organization and supervision of the field work program for university students who specialize in public health nursing.

12. Formal instruction in community health to student nurses in schools of nursing.

13. Interpretation of program and policies to other official and non-official agencies.

14. Participation in national, provincial and local nursing and public health organizations.

15. Evaluation of the present public health nursing program in this department through reports, time studies and statistical analyses. Study of developments in other agencies, provinces or countries with a view to implementation of any method that might add to the value of our present program.

The public health nursing division maintains a liaison with nurses in other divisions within the department, but does not provide supervision. Other divisions employing nurses are the psychiatric services; occupational health; venereal disease control; air ambulance; hospital administration and standards; maternal and child health; and the cancer commission.

Personnel

The public health nursing division presently functions under a director who possesses extensive public health nursing experience, a degree in public health nursing and a certificate in midwifery. She is assisted by two nursing consultants: one with a certificate in public health, a teaching certificate and many years of supervisory experience; the other with supervisory experience and a master's degree in public health. A position for a third nursing consultant is presently under consideration. On September 30, 1959, 148 registered nurses were employed in the division of public health nursing, the health regions and the northern health district. Staff qualifications at that time were:

Master's degree in public health	1
Bachelor of Nursing, nurse midwife	2
Bachelor of the Science of Nursing	9
Bachelor of Nursing	2
Queen's nurse and nurse midwife	3
Health visitor and nurse midwife	2
B.A. & certificate in P.H. nursing	1
Nurse midwife and certificate in P.H. nursing	2
Nurse midwife	4
Certificate in administration and P.H. nursing	3
Certificate in P.H. nursing	43
Certificate in P.H. nursing and psychiatric nursing	2
Certificate in teaching and supervision	2
No qualification above registered nurse	72
Total	148

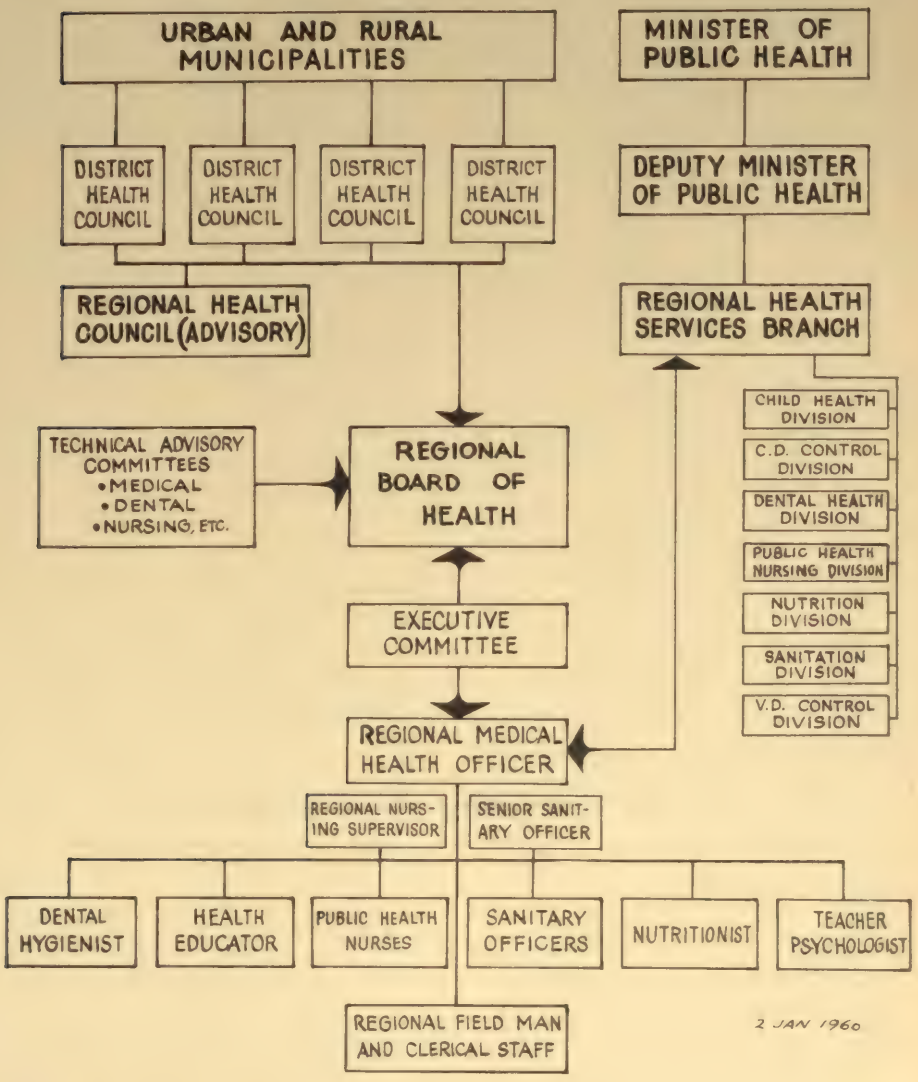
Program

The program of public health nursing includes service to all age groups, but places particular emphasis on the health of mothers and children. The nursing consultant of the division of Maternal and Child assists by providing in-service education for the public health nurses.

1. Maternal Health

(a) Prenatal services: Classes are offered in many areas with the approval and sometimes the help of the local physicians. Home visits are made to

HEALTH REGION ORGANIZATION FOR PUBLIC HEALTH SERVICES



as many pregnant women as can be reached. Teaching emphasizes the need for early, regular medical care, adequate nutrition and hygiene. A fluoride tablet program has been initiated through which women referred by their physicians may obtain tablets free of charge if their drinking water is deficient in fluorine. Water samples are also tested for nitrate content.

(b) Postnatal services: Visits to mothers in hospital are carried out in some areas. Almost all infants are born in hospitals. Postnatal home visits to mother and baby are made whenever possible with emphasis on premature follow-up. Early referrals from physicians and hospitals are encouraged to facilitate this service.

2. Child Health Conferences

These are held monthly in all larger market centres. They provide a counselling service for parents and health supervision for infants and pre-

school children. Protection against smallpox, diphtheria, pertussis, tetanus and polio is offered at each conference.

3. School Service

Teachers are assuming more responsibility for the health supervision of pupils. The nurse's efforts are concentrated on preparation of the child before he enters school. Teacher-nurse conferences allow the teacher to refer children requiring individual inspection, counselling and follow-up. Limited formal health education is carried out. School readiness programs in the form of group meetings are organized to include parents, teachers and health personnel. Emphasis is placed on preentrance medical inspection and on the education of parents to the needs of the child entering school. Nurses also work with teachers in groups, such as Home and School Clubs.

4. Communicable Disease Control

(a) *Immunization:* Protection against smallpox, diphtheria, pertussis, tetanus and polio is provided for all children up to school-leaving age. Immunization against polio has been offered to adults 17-40 years of age during the past three years.

Special immunization clinics are organized as necessary against such diseases as typhoid, Asiatic flu, etc. Gamma globulin is offered to immediate contacts of infectious hepatitis. B.C.G. vaccination is carried on in selected areas by the Saskatchewan Anti-Tuberculosis League.

All public health nurses in the department are certified inoculists.

(b) *Rheumatic fever:* Prophylaxis with oral penicillin is offered to selected cases. Public health nurses supervise follow-up care and report progress. Antibiotics are also available for diagnosed cases of streptococcal infection.

(c) *Tuberculosis:* Case finding, care and control is carried out by the Saskatchewan Anti-Tuberculosis League — a voluntary agency functioning (with provincial grants) directly under the deputy minister of public health. Health education regarding tuberculosis control is included in the public health nursing program. Community attendance at survey clinics, which provide chest x-rays and tuberculin tests, is encouraged.

(d) *Venereal disease:* Contact finding is carried out by public health nurses in rural areas. Free diagnostic and treatment clinics are organized in larger urban centres by the division of venereal disease control.

(e) *Other communicable diseases:* These are investigated and followed up by public health nurses when necessary.

5. Mental Health

Some referrals are made to public health nurses for follow-up of patients paroled or discharged from mental hospitals. Public health nurses assist in visiting patients who attend psychiatric clinics and aid in the referral of maladjusted children.

6. Disabled Persons

Public health nurses aid in the referral of disabled persons for care and do a great deal of follow-up work. They cooperate closely with the Saskatchewan Council for Crippled Children and Adults and the Physical Restoration Division in organizing mobile clinics; reporting on progress in the home; and encouraging prescribed restorative measures. Junior Red Cross cases and persons with visual defects are referred for assistance and are followed up.

7. Nursing Education

Public health nursing consultants work closely with regional nursing supervisors in the following nursing education programs:

(a) *Diploma schools of nursing:* Ten of the 11 schools of nursing in the province have depended on public health nursing consultants and regional nursing supervisors to teach the public health nursing aspects of community health. Efforts are being made to provide public health experience for hospital teaching staff so that they can carry this program. Shortage of qualified public health nurses has allowed only very limited field work experience for diploma school students.

(b) *University public health nursing program:* Field work programs are arranged each autumn and spring for students enrolled in the University of Saskatchewan public health nursing course. The autumn program is for students without previous public health nursing experience.

A public health nursing consultant works with the university staff, regional nursing supervisors and guide nurses in the organization, supervision and evaluation of field work programs.

8. Official and Voluntary Agencies

Public health nurses work closely with many allied agencies such as the Victorian Order of Nurses, the Red Cross, etc. They also have a responsibility for interpretation of the program and health education in the community. This is done through contacts with community officials, health council members and groups such as teachers' institutes and Home and School Clubs. While the department of public health is separate from the department of social welfare and rehabilitation in this province, both headquarters are in the same building and liaison is maintained.

Relationships with other Divisions

As indicated on the accompanying chart, the public health nursing division works with other branches, divisions and regions through the director of the regional health services branch.

Teaching Groups in Urban Areas

RITA DOYON, B.S.

Teaching is one of our chief responsibilities as we go about our task of helping people to stay well or to get well. The opportunities are many and we must know how to take advantage of them.

THERE ARE MANY GROUPS in most urban communities that meet at regular intervals and provide information regarding specific health problems.

Any large urban centre which has one or more universities, several large hospitals, an imposing number of organizations, all of which are interested in health, is an area where considerable health knowledge is disseminated. Nurses constitute one such important group. The ensuing discussion is limited to the teaching done by an individual nurse or a nursing group.

Every nurse is a teacher. From the very first day as a student, teaching patients is an integral part of the care that a nurse gives. It is generally agreed that health education should be incorporated into every nursing activity, irrespective of the setting in which the nurse functions. Every nurse then, carries very definite responsibilities for educating the public, whether she is employed in a hospital or outside of it. In any public health nursing program, teaching is the nurse's most important work and is a continuous performance.

What Teaching Is

As an educator, the nurse needs to possess information that will make her teaching a satisfying personal experience and, at the same time, reach those who are being taught. Teaching is the encouragement and guidance of the learning activities of others, whether they be children or adults. It is the art of helping others to help themselves.

The World Health Organization states:

> The aim of health education is to help people to achieve health by their own actions and efforts. Health education begins, therefore, with people's interest in improving their conditions of living and aims at developing a sense of responsibility in them for their own health betterment as individuals, and as members of families, communities, or governments.

This is the basic philosophy of any public health nursing program.

Teaching cannot be a routine process. It is something that should be original, inventive and creative. It is a genuine intellectual adventure, the primary purpose of which is always to transfer ideas and thoughts to some-

Miss Doyon is assistant chief nurse, Department of Health, Montreal. This address was given last year at the Canadian Public Health Association convention.

one else. Successful teaching necessitates an understanding of how learning takes place and the various factors that influence learning. The nurse must have an understanding of the principles and methods of teaching. She must be able to adapt these to the needs of individual groups. To clarify a topic under discussion, she should know how to use effectively, various visual aids such as leaflets, graphs, posters and films.

As a teacher the nurse needs to possess some understanding of interpersonal relations. She should know how to conduct interviews and other person-to-person contacts, so that these have educational value. She should have the ability to organize and give informal instruction; to lead group discussions with parents, teachers, industrial workers and others. She should know how to develop sound public relations. She must learn to be a good listener and be able to observe whether the learners really understand what they are being taught. Communicating ideas to others demands certain skills that usually come only with practice and experience.

It is imperative for the nurse to cooperate with other agencies in the health field. Her contact with them has value for the agencies and is a stimulating experience for her.

Competence in teaching demands an ardent desire on the part of the nurse to grow — to improve herself personally, to increase her professional knowledge and skill. It requires a thorough knowledge of her subject, subtle insight into student reaction and the ability to get information across. To be able to teach successfully requires adequate preparation of material and keeping abreast of new trends and developments in nursing. Frequent assessment of the content is also essential in order to keep pace with changing conditions in medicine and society. We must continually ask ourselves whether we are meeting the needs of the people we serve and whether we are using methods and terms that they understand.

To achieve competence and success the nurse requires practice. She can learn from observing others. She must be willing to carry on a continuous process of self-evaluation and have a sincere desire to improve. The best teacher always finds room for improvement.

Teaching in the Community

The results of research and contacts with several nursing organizations in a large urban area serve to emphasize the unlimited opportunities there are for nurses to do health teaching. One finds that nurses are constantly approaching groups, but there is so little publicity or fanfare about their work that we are ignorant of it. We tend, then, to form the opinion that very little is being done.

How are groups being approached? One finds nurses very active in teaching or supervising the health teaching for organized groups which require prospective members to have some health information before full-fledged membership is granted, for example, the Girl Guides and Boy Scouts. Certain adults such as applicants to the Junior League, require some knowledge about community health. They usually request a health organization for nurses to address them.

Such groups tend to have a well-defined outline that must be followed. Generally speaking the groups are quite homogeneous and their members share common interests. Their needs, therefore, are relatively easy to satisfy.

There are certain well-known organizations in all large urban centers that offer a variety of courses or classes to the public. Such courses often include general information for the promotion of health and the prevention of disease. A course outline is frequently suggested and the nurses who do the teaching can use it to guide them. Such outlines are valuable and even necessary in directing the nurse's teaching. However, they should serve as a guide only — there should always be room for adaptation to the needs of individual groups. It is impossible to do good teaching and meet the needs of a group when there is little or no flexibility in the program.

The Red Cross Society and the St. John Ambulance Association both give courses in home nursing. Many church organizations offer classes for young couples who are contemplating marriage. Other organizations frequently turn to nurses to act as leaders in dis-

cussion groups with parents, students.

The main problem for the agencies is in securing nurses to do the teaching, since they depend entirely on nurses who volunteer their services. Relatively few nurses seem willing to give their time after the close of their regular work day. Yet the experience and satisfaction derived from such volunteer work are stimulating and rewarding.

It is rather difficult to understand and to accept the fact that so few nurses are willing to offer a few hours each year. As a result, publicity must be kept at a minimum for many classes, and waiting lists are always long. Nurses who do offer their services, from time to time, are answering a great need. They play an important role in improving the health of Canadians.

Nurses employed by official and voluntary health agencies have countless opportunities to do group teaching. This may be a single talk to a particular group or may involve a whole series of classes set up for a specific purpose.

Nurses participate in the teaching of general good health principles and also specific topics such as infant and child care to groups of girls at the high school level. These classes are given at the request of, and in cooperation with, the school's home economics program.

Occasionally nurses are invited to speak at Home and School Association meetings. Ladies' auxiliaries, service clubs, and community centres also call upon nurses to address them. Other groups seek information concerning specific health problems such as cancer, rehabilitation, cerebral palsy or other topics of particular interest to them.

Nurses, in cooperation with the management in many industries, help organize classes and participate in teaching employees. In industry this is usually done by bringing together for discussion, groups of employees who need information concerning a particular health problem.

The general feeling in a variety of organizations is that the teaching that best meets the needs of the people we serve, is incidental teaching — that done with small groups when some incident presents an opportune moment. In answering a need and supplying information at such times as interest is aroused, we are applying the two most important principles of teaching:

1. To begin where the needs and the interests are
2. to guide the learning process forward in such a way that the learner realizes the importance of the nurse's advice, thus creating a real desire to improve himself and his surroundings.

We form small groups daily as we execute our various duties in clinics, elementary and high schools, industry and during home visits. The alert nurse makes good use of every opportunity to do health teaching with such small groups.

Group teaching by nurses in a large urban area is rather fluid and intangible. It is impossible to assess adequately the amount that is actually done. Visits to various nursing organizations and interviews with numerous nurses in the public health field reassure one that work with groups is assuming increasing importance. Nurses realize that people in small groups can support and stimulate one another as they consider their joint health interests. They rarely realize the influence they exert upon the thinking of people in every walk of life. Public health nurses, through their various services, have access to many homes. Here they may plant seeds of understanding. Good public relations, or perhaps we should call them human relations, are a prerequisite. The awakening of an interest in health stems from sound teaching done in the home. This leads to the formation of community groups that are interested in acquiring more information about health.

Group teaching is very interesting. However, we must be cautious and constantly evaluate what we are doing. In a recent report, the World Health Organization makes a statement that is worth pondering:

> Health education is not merely health propaganda or instruction. It aims at enabling the learner to make his own choices and decisions about health matters.

All of our teaching, whether it is done with individuals or groups, should aim at supplying information that will stimulate the learner to favorable reactions and motivate a change in his or her habits.

NURSING PROFILES

The International Council of Nurses recently reported two important staff changes. **Susan King-Hall,** editor of the *International Nursing Review* since June, 1957 has accepted an appointment in Geneva as executive secretary to the International Union for Health Education of the Public. **Yvonne Schroeder,** assistant to the director of the Florence Nightingale Education Division since 1958, and, prior to that, research assistant to the FNIF resigned recently to be married. Her new home will be in Australia. Both of these people have been capable and very valuable members of ICN executive staff. While congratulations are very much in order; the difficulty that will be experienced in replacing them is appreciated and is a tribute to them.

The American Journal of Nursing welcomed its new executive director, **Lucy Doman Germain,** in August of last year. Canadian nurses will be interested to know that Miss Germain was born in Petrolia, Ontario and completed senior matriculation in Canada before going to Farrand Training School for Nurses, now Harper Hospital, Detroit, Michigan. Later she obtained her Bachelor of Science in nursing and teaching in schools of nursing from Teachers College, Columbia University and her Master's degree in vocational education and guidance from the University of Michigan.



LUCY GERMAIN

Her present appointment was very much like a homecoming for Miss Germain. During the years 1940-46 she had worked with the AJN as field representative and was already familiar with many phases of its operation. Her keen interest in professional activities at local, state and national levels has given her a comprehensive grasp of nursing affairs and made her a valuable member of many committees.

Her interest in matters other than nursing is evidenced by her membership in Soroptomist International and, before moving to New York City, in The Women's City Club of Detroit and the Inter-Group Council for Women as Public Policy Makers. A warm welcome is extended to her from across the border.



PEGGY PIKE

A FEW MONTHS AGO the Allan Memorial Institute of Psychiatry, Royal Victoria Hospital, Montreal established a nursing research department and appointed **Peggy C. Pike** to direct activities. Miss Pike has been a staff member since 1946, first as evening and night supervisor, and then as nursing instructor 1948-59.

A graduate of the Vancouver General Hospital, and a native British Columbian, she served with the RCAMC 1945-46 on active duty. She is presently a Captain (Matron) in the RCAMC Reserve. In 1948, she obtained her diploma in teaching and supervision in psychiatric nursing from McGill University. More recently Miss Pike

participated in a short course of study at the National Training Laboratory of Group Development, Bethel, Maine.

As treasurer of the Montreal branch of her alumnae association, corresponding secretary for No. I Battalion RCAMC, Montreal, and, until recently, consultant to the Nursing Service committee, ANPQ, a considerable proportion of her leisure is devoted to the duties involved in these offices. Reading and collecting the craftwork of American Indians are favorite hobbies, but her enthusiasm for travel far exceeds both of these.

Our sincere congratulations are extended to her. Her appointment is a happy choice. Long association with the Institute has given an intimate knowledge of the program of care offered and the philosophy basic to it as well as understanding of mental illness and the problems, nursing and medical, involved in treatment. Through the work of her department she will be putting into practise the conviction that research in nursing problems is most effective when done by nurses.

Prince Edward Island is anticipating the opening of its new Central School for Nursing Assistants at Riverside Hospital, Charlottetown. **Jean Dunning,** who was recently appointed director of the school, is busily engaged in organizing the program and completing arrangements for the admission of her first class of students.

A graduate of Montreal's Royal Victoria Hospital, she obtained her certificate from McGill University in administration in schools of nursing and has led a very busy professional life. She is a former secretary-



JEAN DUNNING

registrar of the Registered Nurses' Association of Nova Scotia. She has been assistant director and acting director of nurses, Sherbrooke Hospital, Sherbrooke, P.Q.; director of nursing, Lachine General Hospital, P.Q.; a V.O.N. district nurse; and more recently a staff member of her home hospital in a supervisory capacity. Her past experiences also include private nursing in Lima, Peru.

The Central School will offer a one-year course of instruction with a 12-week preclinical period conducted at the Shool, 24 weeks of supervised clinical experience in the general hospitals that have schools of nursing and 12 weeks of practice in Riverside Hospital which offers psychiatric care. The final month will be devoted to review classes and qualifying examinations for licensure.

Writing a Report

1. *Who will read it?* A report is not a literary effort. Its purpose is to communicate facts, ideas and opinions. Outline the points before writing.

2. *Get attention quickly:* State the purpose in a few words, itemize and then deal with the facts.

3. *Make it objective:* People want to know what we know; let the report sell itself.

4. *Practise restraint:* Be conservative, avoid extravagant statements, unless supported by facts.

5. *Spell it out:* Avoid making your reader search. List facts in 1-2-3 order set off with headings.

6. *Break it up:* Keep paragraphs short. Indent and underscore important points.

7. *Finish it off:* Conclude report with brief summary of points and/or recommendations.

— A.I.P.E. *News*

* * *

Shelburne, N.S. is full of cairns and commemorative tablets. It boasts an antique fire engine, built in England in 1756, and said to be the only one of its kind in Canada.

— DOROTHY DUNCAN

The Lore of Nova Scotia

PETER O'BRIEN

For those of us who will be visiting Nova Scotia for the first time during the convention many interesting spots await us. This brief review of the lore of the province will serve as an excellent background for such visits.

The Province of Nova Scotia, once known as Acadia, is renowned for its picturesque coastline, island-dotted harbors, beautiful valleys and lakes.

Tradition has it that more than nine centuries ago the Norsemen landed on this peninsula and named it Markland. Five years after the voyage of Columbus, John Cabot, under authority of letters patent issued by King Henry VII of England, crossed the Atlantic and on June 24, 1497, planted the British flag on the northeastern point of Cape Breton Island, Nova Scotia.

Nova Scotia is 374 miles long and 60 to 100 miles wide, with an area of 21,068 square miles. Excepting for the Isthmus of Chignecto, 17.5 miles wide, which connects Nova Scotia to New Brunswick, the province is entirely surrounded by water. Thus there are few sudden changes and extremes of temperature. The highest temperature at Halifax is seldom over 85°. It has 4,625 miles of coastline. The surface of the country is undulating, though not mountainous, the highest ridge being under 1,800 feet in height. Cape Breton is much more rugged.

There is ample opportunity for many kinds of outdoor sports, including golf, tennis, baseball, canoeing, boating, yachting, horseback riding, surf-bathing, sport fishing, deep-sea fishing, big-game hunting, bird shooting. There are 314 trout and salmon streams and 516 trout lakes either adjacent to, or within reach of, the roads and highways in the province.

The 15,221 miles of highways in Nova Scotia are under the direct care and supervision of the provincial government. The population of Nova Scotia is more than 715,000, 77 per cent being of British descent, and 12 per cent of French descent. Education is free, uniform and compulsory. The principal industries are agriculture, fishing, mining, lumbering and manufacturing.

Nova Scotia was settled by five races, the French, the English, the Irish, the Hanoverians and the Scottish. These different races have preserved many of their characteristics, retaining their languages and customs to some extent.

The first attempt at settlement of Nova Scotia was made by Baron de Lery, of France, in 1518. Beyond leaving some livestock at Canso, his trip was a complete failure. On March 7, 1604, Pierre du Guast Sieur de Monts, sailed from France to colonize Nova Scotia. After much exploring he finally established the first permanent settlement of Europeans north of the Gulf of Mexico at Port Royal, near Annapolis in 1605. He was accompanied by Samuel de Champlain who instituted his famous Order of the Good Time, the first social club in America, the following winter.

In 1632, forty families of French farmers from the west coast of France, a country of dyked marshes, came to the province. Soon they were moving to the marshes of the new land which they named "Acadia." The natural increase in numbers was considerable. In 1755, the majority, then known as "Acadians", were deported to Louisiana because of their hostility to the British. Thousands remained, however, and others made their way back during the next decade. Today their descendants form a considerable part of the population. They live together in distinctive Acadian settlements.

The first British attempt at the settlement of Nova Scotia was made in 1621 when King James the First of England and Sixth of Scotland granted the province to Sir William Alexander, a Scottish gentleman. An outgrowth

Mr. O'Brien is with the Nova Scotia Information Service, Halifax, N.S.

of this undertaking was the creation of a Scottish Order of Knighthood, known as the Baronets of Nova Scotia. The Order was conferred upon 140 persons, each of whom was granted a baronetcy of four by six miles in Nova Scotia. The title is still inherited in many Scottish families.

King James named Nova Scotia "The Royal Province" and in 1625 a Royal Coat of Arms was granted, from which was derived the present day Nova Scotia flag. Nova Scotia has the proud distinction of being the first province of Canada and the first colony of Great Britain to possess a flag of its own. For more than a century France and Great Britain disputed ownership of this territory, but in 1763 the British were confirmed in their possession.

In 1753, 2,000 Protestant Hanoverians from the Palatinate and upper Rhine founded the town and county of Lunenberg and proved themselves industrious workers and fine shipbuilders. Nearly 170 years later their descendants built the champion schooner, "Bluenose," which defeated all competitors. These descendants retain a dialect soon noticed by the visitor.

Alexander McNutt, the Irish visionary, hoped to make a fortune by bringing Irish immigrants to Nova Scotia. He brought several shiploads during the latter part of the 18th century, but few families stayed in any district he selected for them. Colchester County, however, was largely Irish in the beginning, and a considerable number of Irish settled in Halifax.

As many as 22 shiploads of New England planters arrived in one day during 1760, when English settlers from New England moved in to take over lands the Acadians had vacated. Within seven years 7,000 of these planters had settled in the province, largely in the Annapolis Valley. Eleven shiploads of Yorkshiremen came during the 1770's, settling in Cumberland County, where descendents remain throughout the farming areas.

After the American Revolution, 25,000 Loyalists arrived, 10,000 of them founding the town of Shelburne.

After the turn of the century the movement of Highland Scottish settlers began, lasting more than 30 years. During that period nearly 50,000 Highland Scots settled in Cape Breton Island and in the mainland counties of Antigonish and Pictou. They clung to their language and traditions and their descendants still take pride in the Gaelic and the kilt. Nova Scotia has the only Gaelic College on this continent and the clan gatherings, highland games and Gaelic Mod are famous.

In the Good Old Days

(*The Canadian Nurse* — MAY, 1920)

International Health Agency — An International Health Agency is soon to be established, under the League of Nations, which will coordinate and strengthen the health work of all nations. The reporting of disease and the maintenance of an international quarantine will be especially dealt with. Typhus seems to be increasing, so that there is great danger of an epidemic spreading over Europe and to this country, if it is not checked. Bubonic plague is also a danger.

* * *

Woman's Day — Women are to be admitted as Fellows of the Royal College of Surgeons, Edinburgh. In England they act as magistrates and serve on juries. A woman is a member of Parliament, four women are qualifying for admission to the Bar. The latter are all young and attractive. One of them, a Mrs. Thomson, said at a legal banquet, "If we are instructed to wear wigs we shall do our best to adapt our back hair to the correct shape of wig." The Lord Chancellor said, "Hear, hear!" A Miss Maud Royden has been pulpit assistant with Dr. Percy Dearmer in Sunday fellowship services on new lines, to appeal to people who do not go to church. We have our "rights" how about our corresponding duties?

* * *

Enfranchised Women — The Belgian Chamber of Deputies has voted in favor of giving women 21 years of age the vote. Mrs. Pothnis Smit, a Socialist, has been elected to the Upper House of the Dutch Parliament. She is the first woman member.

U.N.B.'s School of Nursing

KATHERINE MACLAGGAN, M.A.

Nursing education is taking a "giant step," thanks to the philosophy and objectives of New Brunswick's new school.

THINGS have been happening in nursing circles in New Brunswick because the leadership of the past dozen years has been superimposed upon the course of natural events. The New Brunswick Association of Registered Nurses, through its Executive Council, through its standing and special committees, by its almost obsessive cooperation with existing institutions, with educators, doctors and laymen, seized and directed and to a degree fermented these natural events which are resulting in desired change.

One can pinpoint such tangible changes as the establishment of the new School of Nursing at the University of New Brunswick in 1958; but elusive things such as positive attitudes, objective thinking and patient determination are not so easily pigeonholed in time and place. That these elusive things engender and generate the power necessary to action we have learned well. And what a comfort it is to know that financial support succeeded rather than preceded such action!

Because its roots are in the nursing needs of the present day, one cannot isolate the story of the establishment of U.N.B.'s School of Nursing from the soil in which it developed. Nor would one hope to analyze all the ingredients which nurtured it. Such printed words as the Weir Report of 30 years ago, the Report of the Health Survey of the Province of New Brunswick and the Wright Report of 1951, the Russell Report of 1956 exerted their influence. The advisory Committee on Nursing in New Brunswick (first formed of laymen and nurses in 1948 and still active), the public conferences and the private conferences, the organized meetings and the unorganized meetings, the conflict and the consensus kept nursing and its case viable. And always, the sometimes nurse and sometimes layman leadership in this inexorable series of events managed, with varying degrees of heartening skill and ridiculous error, to maintain a delicate, balance between the presentation of ideas and their rate of implementation.

Eventually, the thought that the University of New Brunswick should search for a form of nursing education which would best serve both the profession and the people was not a strange one, but rather a sensible one. With the acceptance of this thought came the magic of the W.K. Kellogg Foundation Grant to the university for the purpose of establishing a school of nursing that would evolve an academic and professional curriculum for undergraduate students of nursing and that would undertake, by itself or in cooperation with others, to give all reasonable aid to nursing education, generally, in the province.

Since the best of magic has an earthy explanation, it goes without saying that the formal and detailed request to the Kellogg Foundation was documented with care by the University. In due course but not necessarily in sequential order there arrived a faculty of four nurse educators, a building in which to house the school, some furniture, some books, some equipment (through a federal-provincial grant from the Department of Health) and fifteen students. And we were in business.

A detailed exposition of curriculum, sequence of courses and course content, working relationships with hospitals and public health agencies must wait for a more appropriate time in the pages of this *Journal*. In the meantime, a statement on the beliefs about nursing education, epitomizing the work of the new faculty and the students, is in order.

We believe that ministering to basic human needs, within the framework of

Miss MacLaggan is Director and Professor of Nursing, School of Nursing, University of New Brunswick, Fredericton, New Brunswick.

a specific culture, is the core of nursing practice, regardless of the degree of health portrayed by the individual or group. Since nursing is a service performed by individuals for individuals and groups on a personal basis, we believe that its practice is closer to applied social science than it is to applied physical science. At the same time we believe that nursing knowledge is a synthesis of the social and the physical sciences, together with its own body of knowledge and skills. We believe that nursing knowledge, enveloped in as broad a general education as possible, should be demonstrated through the application of principles rather than through "this is how to do it" techniques. For this reason, the accent in our program is on content rather than on method.

We believe that much of our social legislation has yet to reveal its true impact on nursing. To see the impact in terms of quantity, without at the same time appreciating the impact on quality in terms of the nursing role itself, would be an error of giant size. The provision in our Hospital Care Insurance Act of "necessary nursing service" for every patient in our hospitals is a case in point. What is "necessary" will long be debated by doctors and nurses and patients, but in the long run nurses will, in our opinion, direct and administer as well as provide the nursing service deemed by them to be necessary. More than ever before, our legislation which "socialized" nursing has brought home the point that nursing, at least at the upper echelons of its practice, must move from the technical service role to the social service role.

The present struggle, going on everywhere in Canada, is in essence the struggle of any group which is being forced by society to change from a technical occupation to a professional one. We believe that such a transition can be achieved through education and that the university is the proper milieu for this education.

While an increasingly large number of those who nurse for hire must be professional nurses, we believe that technical nurses are essential to the nursing service of the community and must be well trained. In searching out ways and means of separating education from service, we believe that a pattern of replacement for the present system is urgently needed.

Keeping forever sacred the historical association of nursing with the medical profession in terms of medical diagnosis and medical treatment, we believe that nursing is in a position to identify and to meet needs not easily recognized or easily assumed by other health disciplines. With better education, it is our opinion that additional new functions, not impinging upon medical diagnosis *per se,* will be assumed in a natural and sensible fashion.

So long as the need for nursing is universal and the nursing service is unrestricted by considerations of nationality, race, creed, color, politics, or social status, we believe that the professional nurse can move safely and productively on such a sociological tightrope only if she possesses a broad general education.

We believe that the function of the professional nurse has its mainspring in principles which require knowledge gained from the humanities, the biological, the physical and the social sciences.

Clothed in such a background, our objective can be simply stated, as follows:

To move the practice of nursing from the technical level to the professional level for a selected group of young people who are motivated to become nurses and who have the ability to achieve professionalism.

We propose to do this by:

Making the humanities and the biological, physical and social sciences an integral part of professional education in nursing;

presenting the theory of nursing at the university level of study in order to foster an intellectual approach as opposed to a technical approach to nursing content;

using the clinical facilities of the hospitals and of the public health agencies so that the student absorbs, interprets and learns from the vast amount of material available;

freeing the student from the service needs of the hospital or agency in order to devote her time and energy to learning;

organizing the curriculum so that the study of nursing and the arts and

sciences will run concurrently, in the hope that one will have its impact on the other;

qualifying our students for beginning positions in the nursing field;

qualifying our students for registration in the province of New Brunswick;

qualifying our students for admission to graduate work in the nursing specialities.

Some day, several years from now, we will be asking the consumers what they think of the products of our educational program. In the meantime, we as a faculty shall not hesitate to exercise our right to change our pattern at the first hint of error.

Less nebulous than our few months old undergraduate program is what we self-consciously call our *continuing education program.* In essence, this is an adult education effort, designed to upgrade the nursing service in patient care and to ensure clinical practice worthy of demonstration to students of nursing.

The University of New Brunswick inherited, as it were, this well-constructed program from the New Brunswick Association of Registered Nurses. The faculty of our school, together with imports from other parts of Canada and from the United States, act as consultants in the various nursing specialities. Through the media of institutes, refresher courses, work conferences, correspondence with and follow-up visits upon request to hospitals, and this July and August, our first summer school for graduate nurses, we reach a great many members of the nursing force of the province. Most of the offerings have been open to nurses from the Atlantic Region, although nurses are welcome regardless of their place of residence.

An Advisory Committee, composed of nurse representatives from the New Brunswick Association of Registered Nurses, the Department of Health and Social Services and the Hospital Services Commission of the province help the faculty of the School of Nursing to design the content of the continuing education program. Our few months' worth of satisfying effort, as seen in the attendance at some phase of the program of over 630 nurses, or approximately ⅓ of the active membership of the NBARN, is due largely to the work and insight of our Advisory Committee.

The object of the Advisory Committee and the School of Nursing is to plan the total program so that every phase of nursing practice is served. Directors of nursing and nurse educators participated in a conference on planning the budget and the rotation of students in hospital schools of nursing. Invited for one session were hospital administrators, board members, Hospital Services Commission executives, and all other appropriate people. This type of thing is done in the interest of keeping the people with a vested interest in nursing with us. These same people, so important to the good health of nursing, have been invited to attend one session of the week-long conference on "planning schools of nursing of the future" currently projected.

The institute on the maternity cycle — planning for the continuity of care for the mother and child was blueprinted for public health nurses and obstetrical and pediatric nurses in hospitals. Incorporating the sciences into the curriculum of schools of nursing is a continuation of last year's effort on curriculum development for teachers in schools of nursing.

Our first venture into a six weeks' summer school is on ward administration, and is offered to those who wish to have some preparation in the administration of the nursing service.

The one week refresher course on the physiology of patient care, held consecutively in five centres in the province, drew 550 nurses from every type of nursing occupation — surely tangible evidence of the willingness of our nurses to identify with Kathleen Russell's advice in her Report of a Study of Nursing Education in New Brunswick.

Lower Granville, N.S., is the oldest permanent white settlement north of the Gulf of Mexico. An exact replica of Champlain's original habitation, built in 1605, stands on the site of the first buildings.

— Dorothy Duncan



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please send reprints of the following articles:

- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

Your Name and Address



PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Our Executive Meets

By the time this issue of *The Canadian Nurse* appears, the Capital will be a tulip wonderland. As this was written, a state of emergency had been declared in Ottawa as the city was battered by 17 hours of driving wind and snow. Buses were late, taxis refused to run. Parked vehicles were trapped and all but buried in the choking drifts that climbed high against every obstacle in the path of the windborne snow. The Executive Committee was meeting at the Chateau Laurier where most of the members were staying. National Office staff battled the elements to reach the hotel. Some were successful!

Pilot Project Report

The results of a two-year study project representing the most exhaustive enquiry into Canadian nursing education in 32 years was presented to the Executive Committee. The report was presented by Miss HELEN K. MUSSALLEM who directed the study. The recommendations will be presented to the general membership at the Canadian Nurses' Association Biennial meeting in Halifax. Miss Mussallem was given an overwhelming ovation at the conclusion of the presentation of the report. She was later interviewed by the press, a local radio station and on television by the CBC. Numerous press clippings were received in National Office from across Canada.

The report is being printed in both French and English. Requests for copies should be directed to: **Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.**

Other Highlights of the Executive Meeting

National Office staff had the opportunity at this time of entertaining the Executive and local health and welfare personnel at a buffet supper in our new office.

Nursing Service

Included in the report of the Committee on Nursing Service was a draft of a manual — "A Guide for Head Nurses in Hospitals." It is hoped that the manual will be valuable to the head nurse in helping her to understand her responsibilities, to improve her methods, and to comprehend and apply sound principles of administration so that the best possible nursing care may be provided. It should also help her associates understand and appreciate her role.

The Executive Committee approved the printing of the manual. It is hoped that it will be ready for distribution at a nominal charge at the Biennial Meeting in June.

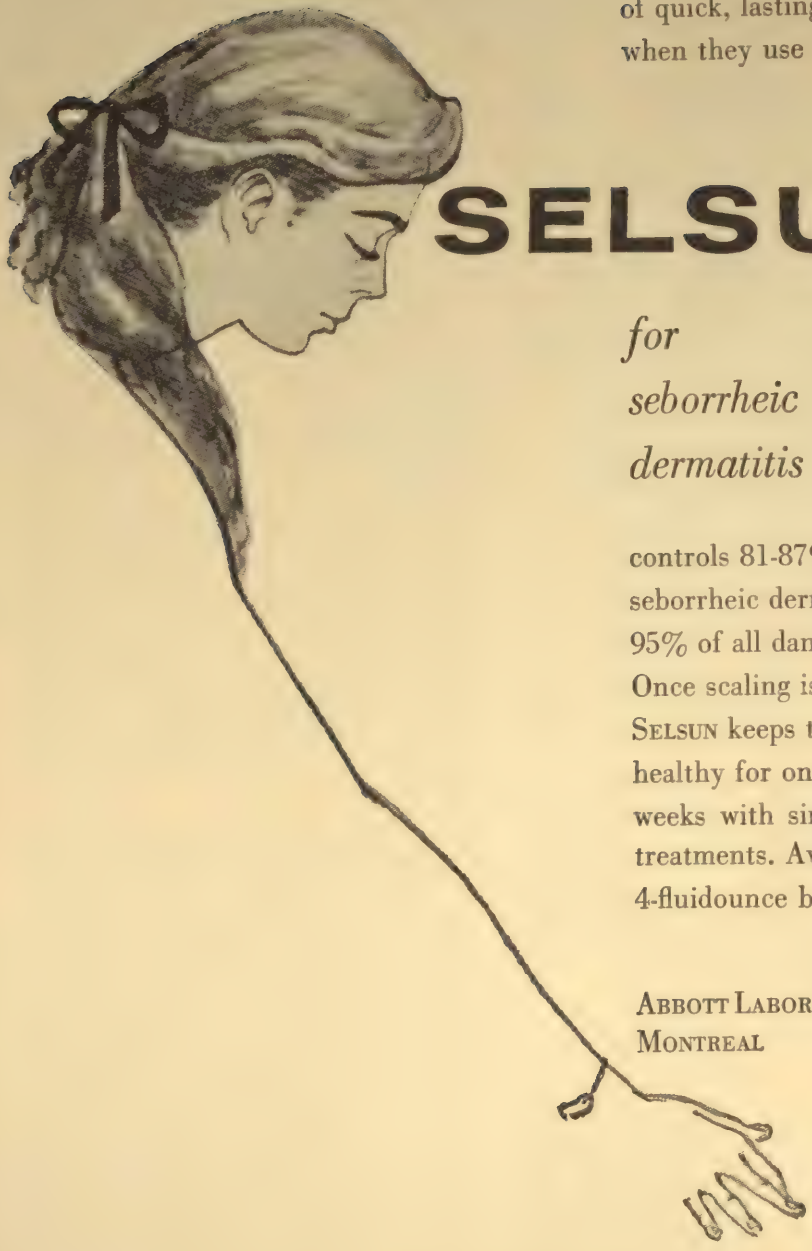
Two statements prepared by the Committee on Nursing Service, one on Job Satisfaction, the other on the Implications for Nursing in Organized Home Care Plans were also approved. These will be prepared in pamphlet form and made available for distribution.

The need for a study of quality of nursing care and for a statement of criteria for the evaluation of nursing care was discussed and it was agreed that the CNA should initiate such a study.

Nursing Education:

The report of the Committee on Nursing Education included a review of the Curriculum Workshop that was held in conjunction with the meeting of that Committee last November. The papers presented at the Workshop by Miss FLORENCE ELLIOTT, coordinator, contained much valuable and stimul-

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ating material. They will be published later in *The Canadian Nurse.*

Miss HAZEL KEELER, chairman, discussed the findings of a survey carried out by her Committee last September. It was interesting to note that the findings of this survey, closely paralleled the findings of the Pilot Project for Evaluation of Schools of Nursing.

Public Relations:

The scripts prepared by the Public Relations Committee for two new nurse recruitment pamphlets were approved. They will be developed for distribution in the near future.

The Provincial Associations

The Registered Nurses' Associations of British Columbia, Saskatchewan, Alberta and New Brunswick are holding their annual meetings this month.

Faith

National Office is a hubbub of activity with the final preparations for the 30th Biennial Meeting in Halifax. Have you registered? There is still time. Avoid the crush of crowds at the registration desk. Fill in your application forms that were included in last month's issue, make out your cheque, and mail it straight away. The nurses responsible for arrangements will see that you are well taken care of.

Business Firms Assist CNA

Once again the T. Eaton Company Limited is providing the attractive programs for the CNA General Meeting. The cut for the cover, showing the Old Town Clock at the foot of Citadel Hill, was provided by the Tourist and Convention Bureau of Nova Scotia.

Post-Convention Tours

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In these days of fast, luxurious air service, distance doesn't matter any more. Europe is within easy reach of anywhere. And once there, you can forget your worries and your eyes will be opened . . . . . .

See how others live, work and play. Leave London 2:10 p.m., arrive at Montreal 5:20 p.m. . . . same day.

There are still a few openings for the 36-day tour following the 30th Biennial Meeting in Halifax.

Brochures available at CNA National Office, 74 Stanley Avenue, Ottawa.

Local Tours

Bermuda-bound nurses or those interested in a New York fling following the convention may obtain all pertinent information and make reservations by contacting MR. R.F. CUMMINGS, Assistant General Manager, **Thos. Cook and Sons, Dominion Square Building, 1241 Peel St., Montreal, P.Q.**

St. Pierre and Miquelon, French islands in Atlantic water with many commodities from France, can be reached by air or boat in a very short time with an interesting stop-over of two days.

Newfoundland, Canada's youngest province, steeped in tradition, provides unusual attractions and comfortable accommodations.

For detailed information and specific arrangements contact: MR. ROY BOWMAN, Manager, Maritime Travel Service, **76 Granville St., Halifax, Nova Scotia.**

Tours can be arranged for any one of the Maritime Provinces: Nova Scotia, New Brunswick and Prince Edward Island each with their own unique charm and beauty, or can be planned to include the most interesting features of each province. For information and specific planning contact: MR. DAN WALLACE, Manager, Provincial Tourist Bureau, **Hollis Street, Halifax, Nova Scotia.**

Notes from The Royal College of Nursing, London

It was with great pleasure that the Council received the news that a World Health Organization travelling scholarship had been awarded to Miss MARGARET D. STEWART, secretary to the Scottish Board. Miss Stewart is to spend two months in Canada and United States studying professional nursing organization activity.

Research is indispensable for the advancement of any profession, and for a long time the Council of the Royal College of Nursing has been aware of the need to promote research into nursing. It is recognized that research is a proper function of a professional association, and for this reason the proposal to form a nursing research board or committee of the Royal College of Nursing was agreed to in prin-



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ciple five years ago. Although this proposal has not been implemented, it has nevertheless been kept constantly under review. The Council now feels that the time has come when the Royal College of Nursing must give a lead to the profession in the matter of nursing research. It has formally decided to set up a nursing research body within the College. The purpose of this Board will be to advise the Council on all research matters.

International Essay Competition

Nurses from 15 countries were among the finalists in the International Essay Competition organized by the Ethics of Nursing Committee of the International Council of Nurses.

The international panel of judges decided to divide the first prize in both sections of the competition. The winners they chose were: Miss GERTRUDE H. SWABY, a sister tutor in Jamaica, and Miss ARNOLD LANCASTER, a sister tutor in Scotland, for their essays in the first section — "The International Code of Nursing Ethics: how it can be brought into nursing schools, and ways and means of integrating teaching so that ethics may be included in all nursing subjects." In the second section, in which competitors were invited to write on one of the ICN "Watchwords," the joint winners were: Miss KAREN PEDERSEN, a head nurse in Denmark, who wrote on "Life," and Miss P. W. REDMAN, now a Deputy Matron in England, whose subject was "Responsibility."

In addition, the judges made honorable mention of Miss HELEN CAMPBELL, of New Zealand, for her essay in Section I, and SCHWESTER ELFRIEDE HELDT, of Germany, for her essay on "Wisdom," entered for Section II.

The essays entered for the competition were first considered by a national committee, which was set up by each national nurses' association to select not more than one essay in each section for consideration by the international panel of judges.

The joint prizewinners each received £12 10s. and a free subscription for two years to the *International Nursing Review,* now to be published six times a year at an annual subscription of 30 shillings sterling, and containing articles in English, French, German and Spanish. The winning essays in Section I have been published in the February 1960 issue, and those in Section II in the April 1960 issue.

MACMILLAN AWARD WINNERS

When the six widely scattered judges returned their reports to the *Journal* office respecting the studies on comprehensive nursing care submitted by student nurses during 1959, the city of Edmonton could claim a sweep of the cash awards. The topics chosen for the articles showed considerable variety. The quality of writing was unusually high. We congratulate the winners not only of the cash awards but also those who secured Honorable Mention. These six articles will be published in the July, 1960 issue so that every nurse may see if her opinion coincides with the judges.

Awards of $25 each to:

Miss Rosemarie Perka, Edmonton General Hospital, Edmonton, Alta.

Miss Emiko Adachi, University of Alberta Hospital, Edmonton, Alta.

Honorable Mention (alphabetical order):

Miss Kathleen A. Doonan, Hotel Dieu of St. Joseph, Windsor, Ont. Miss Mona Eisenstat, Jewish General Hospital, Montreal, Que. Miss Carole Eldridge, Royal Columbian Hospital, New Westminster, B.C. Miss J. Kuriatnyk, Edmonton General Hospital, Edmonton, Alta.

These awards are sponsored annually by the Macmillan Company of Canada, Ltd., 70 Bond Street, Toronto. Instructors are urged to encourage their students to participate in the 1960 competition by polishing up good nursing care studies and submitting them to the *Journal* office, **1522 Sherbrooke Street West, Montreal 25, Quebec.**

There are 100-year-old wells in the middle of several streets in **Shelburne, N.S.,** which still provide good water.

— DOROTHY DUNCAN

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TENTATIVE PROGRAM

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THEME: — *"Faith"*

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June 19 - 24, 1960

Sunday - June 19th

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Official Opening ..... International, National and Civic Dignitaries
Greetings ..... Miss Alice Sher, Assistant Secretary, I.C.N.
..... Miss Lily M. Turnbull, Regional Nursing Advisor, W.H.O. Western Pacific Regional Office.
..... Mrs. Judith G. Whitaker, Executive Secretary, American Nurses' Association, U.S.A.
..... Miss Lucy D. Germain, Executive Director, American Journal of Nursing Company, U.S.A.
Response to Greetings
Roll Call of Federated Associations
Introduction of representatives of Commercial Exhibitors
Welcome from the Mayor of Halifax ..... Mr. Charles H. Vaughan
Keynote Address

AFTERNOON

The Presidential Address ..... Miss Alice Girard
Finance Committee Report ..... Miss Helen Carpenter
Reports of General Secretary-Treasurer ..... Miss M. Pearl Stiver
Special Student Session

Garden Party

Halifax Public Gardens

5:00 - 7:00 p.m.

Tuesday - June 21st

MORNING

The President presides .....
The Pilot Project on Evaluation of Schools of Nursing
Report ..... Sr. Denise Lefebvre
Report of the Director ..... Miss Helen K. Mussallem
General Discussion .....
Presentation of Recommendations .....
Special Luncheons

AFTERNOON

Special Interest Groups Discussion re: Criteria

EVENING

Special Speaker
Summary of Group Discussions ..... Miss Hazel Keeler



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Wednesday - June 22nd

MORNING

"The Patient Returns to the Community"
Case Conference ..... Dr. Gustave Gingras, Director, Rehabilitation Institute of Montreal

Free Afternoon

Cruise on Harbor and lobster supper planned at .....

Thursday - June 23rd

MORNING

President's Conference .....
A presentation of Committee Activities ..... Committee Chairmen

AFTERNOON

"The Impact of Hospital Insurance on Patient Care" .... Minister of Public Health of Nova Scotia

A panel discussion — Implications for Nursing

EVENING

President's Reception for CNA members and guests
Music by Armdale Chorus

Friday - June 24th

MORNING

Press Conference on Nursing Legislation ..... Miss Pearl McIvor, Chairman, Committee on Revision of Constitution and By-Laws, I.C.N.
Miss Lucy D. Germain, Executive Director, American Journal of Nursing Company
Miss Margaret E. Kerr, Executive Director, *The Canadian Nurse*

Voting on Resolutions
Report of Scrutineers

AFTERNOON

Address — "Faith" .....
Conferring of Honorary Memberships .....
Installation of officers .....

Reception — The Nova Scotian Hotel
Guests of
The Registered Nurses' Association of Nova Scotia

The booklet "Heart Disease Caused by Coronary Atherosclerosis" has been completely revised to bring the text and illustrative material up to date. Suitable for distribution to patients, the booklet contains a discussion of heart attacks and the process of recovery, an explanation of the nature and treatment of angina pectoris and a description of the atherosclerotic process. Copies may be obtained from the American Heart Association, 44 East 23rd Street, New York 10, N.Y.

* * *

A collection of sea curiosities, old coins, Indian relics and possessions of some of the first settlers are on display in the museum in the Town Hall, **Bridgewater, N.S.**

— DOROTHY DUNCAN

Injuries during embryonic growth leave a distant imprint in the form of "disturbed growing rings" on a child's baby teeth. This makes it possible to pinpoint the exact time in fetal life when injury occurred. Further research shows that cerebral palsy complicated with athetosis is due to a brain damage of longstanding — the disturbed growth ring on the teeth of a child with cerebral palsy was formed during the fifth month of fetal life. — Squibb *Nurses' Notes*

* * *

Lunenburg, N.S., is the home of the greatest deep-sea fishing fleet in North America. **Blue Rocks,** five miles down the shore, and **The Ovens,** 12 miles away, are both worth a visit, the former having been painted by innumerable artists. — DOROTHY DUNCAN

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First Vice-President:	Miss E. A. Electa MacLennan — by acclamation	Director, School of Nursing, Dalhousie University, Halifax, Nova Scotia. (presently — Second Vice-Pres.)
Second Vice-President:	Miss Hazel Keeler	Director, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan. (presently — Second Vice-Pres.)
	Miss Sheila Nixon	Nursing Consultant, Division of Standards, Manitoba Department of Health & Welfare, Winnipeg, Manitoba.
Third Vice-President:	Miss Hazel Keeler	Director, School of Nursing, University of Saskatchewan, Saskatoon, Saskatchewan. (presently — Second Vice-Pres.)
	Miss Geneviève Lamarre	Director of Nursing Education, Hôpital de l'Enfant-Jésus, Quebec, Quebec.
	Miss Katherine MacLaggan	Professor of Nursing, School of Nursing, University of New Brunswick, Fredericton, N.B.
	Miss Mary Richmond	Director of Nursing, Royal Jubilee Hospital, Victoria, B.C.
	Miss Marguerite E. Schumacher	Advisor to Schools of Nursing, University of Alberta, Edmonton, Alberta.
	Miss Janet Story	Instructor, Medical Nursing, General Hospital, St. John's, Newfoundland.

Representatives of Nursing Sisterhoods:

Sister Anne Antoinette	Director of Nurses, Notre Dame Hospital, North Battleford, Saskatchewan.
Sister Mary Elaine	Associate Director of Nursing, St. Mary's Hospital, Montreal, Quebec.



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Sister Cecile Leclerc.....Director of Nurses, Holy Cross Hospital, Calgary, Alberta.
Sister Mary Loretto.....Administrator, St. Vincent's Hospital, Vancouver, B.C.
Sister Madeleine of Jesus..Director, School of Nursing, University of Ottawa, Ottawa, Ontario.
Sister Mary Melanie.....Superior, St. Mary's Hospital, Montreal, Quebec.
Sister St. Odilon.....Director of Nursing, Misericordia Hospital, Winnipeg, Manitoba.
Sister M. Patricia.....Director of Nursing, St. Joseph's General Hospital, Port Arthur, Ontario.
Sister M. Rosarie.....Educational Director, Holy Family School of Nursing, Prince Albert, Saskatchewan.
Sister Hugh Teresina.....School of Nursing, St. Michael's Hospital, Lethbridge, Alberta.
Sister Mary Xaverius.....Superintendent of Nurses, St. Clare's Mercy Hospital, St. John's, Newfoundland.

Rx for a Delegate

"The convention was good. I didn't get to that closing business meeting because I had to go shopping. We had a good spaghetti dinner, but the banquet was too expensive. Oh yes, as you told me, I voted against the one issue, but, you know, I found out we really should have voted for it. Yes, that's all of my report."

You may think the above is far-fetched, but it is somewhat typical of convention reports in general . . . Just what are the responsibilities of convention delegates?

A nurse, once selected as delegate, should plan on getting to the convention on time and attending all general business meetings. Program meetings, too, are part of a delegate's responsibilities, for when a district sends a delegate, it is really the delegate's obligation to report thoroughly the significant events of the convention.

When delegates attend business meetings, they should listen to the pros and cons of specific issues. Voting is a privilege and delegates should try to vote intelligently on issues. If possible, delegates should be informed on issues and members' views of them before attending the convention but delegates should not be instructed how to vote. If all delegates were instructed before attending a convention there would be little need for a convention, let alone for explanation and discussion of issues.

At the 1958 American Nurses' Association convention, it appeared that some delegates, instructed to vote against a dues increase, became personnally convinced, after discussion, of the need for an increase. What a dilemma! To vote against something, as instructed, even though one is sure the members at home would be in favor if they heard the whole story, or to vote for it, as the delegate believes is right.

Following convention, delegates should . . . go to the next district meeting and report on it. If a district sends several delegates to the convention, they might do well to divide up the reporting so that all will not be describing the same events.

In making such reports, it is well to remember that although the social affairs of the convention might be highly interesting, the business of the convention is what is significant. Therefore, with the inevitable flood of business at a post-convention district meeting, convention reports should be specific and relate to the important aspects of the convention.

Gossiping about the banquet or about the weird or impressive clothes of other delegates may be indulged in at coffee time.

— *Washington State Journal of Nursing*, February 1959.



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Play Therapy and the Nurse

Françoise Miller Ouellet, B.Sc., Ed. N.

This is the second half of an article which appeared in the April issue.

The Nurse's Role

Play is essential to a child's development. The concept of play as part and parcel of the total plan of nursing care is compatible with this principle. It is the hospital's responsibility to plan for the use of the child's free time.

The program will depend to a large extent on the number and competence of the personnel. The nurse plays an important role and cannot sidestep her responsibility since play therapy is carried out under her guidance.

The Head Nurse

One of the first persons with whom the child comes in contact is the head nurse. Through her understanding, sympathetic attitude, the child is helped to adjust quickly to his new environment. In the development of the recreational program, the head nurse may be called upon to organize the leisure-time of children both from within and outside of her own department. It is her duty to correlate activities; to prevent unnecessary use of energy; to carry out general, constant supervision.

In organizing the child's day it must be remembered that activities should be such as to promote health and meet the needs of his growing body. For this reason, the day's program can not be planned in advance. What the child is permitted to do must be correlated with his medical care to ensure physical and emotional well-being. His illness may limit the child's activities but the convalescent ordinarily needs a great deal of attention. As he regains his strength, he must be encouraged and helped to get back confidence in himself. The head nurse must be understanding of her young patient's daily frustrations and disappointments, such as his slower recovery in comparison to that of his friends. If she fails to pay attention to this, it may retard the child's progress. Once he is fully convalescent, the child becomes more active and participates to a greater extent in his own recovery but he still needs encouragement.

The nurse must educate the family to let the child do things for himself even if the task is accomplished very slowly. Otherwise their attempts to help may prove an actual hindrance to recovery.

Each new staff member should spend a certain length of time with the personnel who are responsible for the recreational program. Here she learns to appreciate the fact that play is as important for the sick child as for the well child. Even if the time spent in the department must be limited, an attempt can be made to provide a variety of experiences and broaden the nurse's concept of the child as a patient.

The emphasis placed on "the patient" is modified by the philosophy of nursing care in relation to children. A child is, first of all, a child and then, a *sick* child. Within the limits of his physical disability he has the same interests as other children of his age. During his hospitalization, he can be helped to make new friends and develop new interests. In orienting staff members to the role of the recreational program they must be made to realize that it is not just a means of keeping the children busy but that it is a part of their general care and treatment. Participation in it helps to develop a sense of security in the child and increases his confidence in the hospital personnel.

The personnel of the department take part in numerous conferences. The needs of each child are discussed and a program outlined. Through these discussions, the personnel become familiar with their individual behavior and are better prepared to help them. Play activities are organized as soon as

Mrs. Ouellet is on the teaching staff of St. Justine's Hospital, Montreal. This is the concluding section of her article.

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the head nurse has chatted with the child's mother and found out his habits of eating and sleeping, his preferences as to games and toys. This information should be included in the child's chart.

For the children who will continue their school lessons while in hospital, the nurse and the teacher together will decide upon the best time of day for instruction. The nurse must make sure that nursing care is completed early enough so that the children can rest before class. She sees to it that they are comfortably settled, particularly bed patients, so that they do not become too tired. Ideally their school lessons should provide relaxation through change of activity.

If the parents tend to be critical of the program, the nurse should arrange for them to have an interview either with her or with the teacher. They should be helped to see that the school program is really a means of diversion for the child as well as keeping him on a level with his schoolmates. The nurse has another opportunity to help the child here by seeing to it that "homework" is done and advice given as required.

A quiet, peaceful environment is necessary to interest children in reading. The nurse must be well-read herself to carry out her role as a guide. She will have the task of looking after the classroom books — seeing to it that they are kept clean and that they do not leave the hospital. It is to be expected that some books will disappear from time to time but an attempt must be made to avoid this.

The Student Nurse

Play is such an important part of a child's life that it seems impossible to teach pediatrics without considering it. It must be impressed upon the student nurse that the care of the child has as close a relationship to his growth and development as to his illness. The play program is a rich educational experience for her in acquiring a better understanding of the young. As she becomes familiar with the materials used, the nurse will appreciate their value in the rehabilitation of the child and she will be better prepared to interpret the child's needs in regard to play.

The student must be taught to take the child's behavior and the effect of organized leisure-time into account. She should be encouraged to discover the type of occupation best suited to the individual. In this way she will learn to associate properly planned leisure time as part of the total care.

A professional nurse should be thoroughly familiar with normal personality development as preparation for her work in pediatrics. The head nurse and the clinical instructor must take advantage of every opportunity to help the student acquire this knowledge.

Advantages of a Recreational Program

For the Child

1. Provides an opportunity to work off excess energy and promotes relaxation.
2. Provides a good means of adjustment to physical and social surroundings.
3. Provides a means of diversion and also teaches moderation in the use of leisure-time.
4. Helps to develop a more acute sense of values.
5. Encourages inventiveness and stimulates the development of new interests.
6. Relates play and work to individual needs according to physical, social and mental development.

For the Nurse

1. Helps her to see each child as an individual to be respected.
2. Promotes a better understanding of the child thus making nursing care more effective.
3. Acts as a stimulus. By comparing her role to that of the mother, the nurse understands her responsibilities more fully.
4. Introduces diversion into the routine of medical and nursing care.
5. Promotes development of her own personality through exploration of a new field of action.

Recreational therapy, combined with nursing and medical care, has considerable value. The sick child no longer feels alone. His adjustment to the hospital environment is made easier. He feels happier generally and his recovery tends to be more rapid.

The pediatric nurse should participate actively in such a program. She should work in cooperation with all other members of the team to use recreational therapy most effectively.



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THE PROVINCES REPORT

With the biennial meeting rapidly approaching, the Executive Committee of the CNA met on February 18-20, 1960 in preparation for it. That the past two years have been very busy was evidenced in the reports of the federated members. A general survey of these indicates an increasingly heavy program with a corresponding need for more funds to carry out projects. To meet financial requirements several provinces either reported increases in fees or their plans to submit such amendments to their memberships. Committee activity appeared to have reached a new high with each association reporting a variety of institutes, workshops, study days, conferences and special programs. Considerable effort is being expended to ensure that nurses, active or inactive, are kept informed of professional developments.

A comparison of total registration figures for the years 1958 and 1959 reveals a noticeable increase in eight provinces. In the two provinces where *total* registration figures were not increased, there was a marked decrease in *inactive* registration. This also applied, however, to provinces where the overall total was up. With the return of so many non-practising members to active professional life, provincial associations have sought to meet their special needs through refresher courses. It is interesting to note that in one province 50.8 per cent of practising members were married women while another province reported 60 per cent.

Another trend appears to be a closer working relationship between nurses' associations and various medical groups such as hospital associations, medical associations and hospital insurance groups. In some cases, the relationship has provided an opportunity to discuss mutual problems; in others it was formed for educational purposes, and in still others to request the assistance of nurses in obtaining information. With some exceptions, many provinces that have adopted the federal-provincial scheme of hospitalization have appointed a nurse consultant (or consultants) to the commission. It is hoped that eventually each province will adopt a similar pattern. All of this would seem to indicate that nursing is assuming ever greater stature as a profession in its own right—that it has come of age.

Alberta

1. Established a liaison committee with the Alberta Medical Association with discussion of mutual problems as one objective.

2. Provided a variety of institutes and refresher courses.

3. Undertook a pilot project for the care of the chronic and aged within the borders of a northern chapter, under the financial sponsorship of the Canadian Red Cross Society and the provincial government.

4. Is conducting a nursing care survey for the purpose of determining and setting up standards. This is under the sponsorship of the provincial government and includes representation from the Associated Hospitals of Alberta.

5. Is studying proposals from various companies regarding a possible income disability plan.

British Columbia

1. Provided hospitals with a guide for refresher courses.

2. At the request of the Hospital Insurance Services, undertook two special studies: 1. The planning of nursing units and 2. the concept of progressive patient care.

3. Appointed a Committee on Ethics and employed a psychiatrist on a fee-for-service basis for more effective handling of abnormal behavior within the membership.

4. Adopted provincial bargaining as promoted by the British Columbia Hospitals Association and achieved a marked degree of uniformity in salaries and personnel practices within public hospitals.

Manitoba

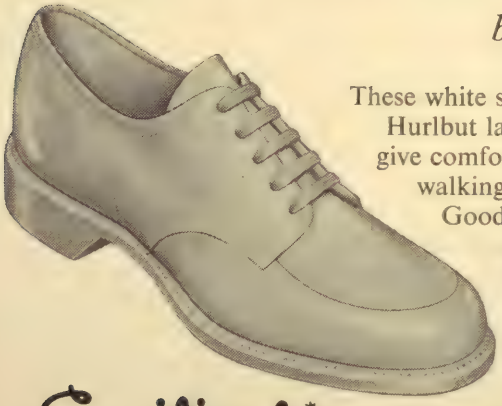
1. Arranged for an extensive series of institutes and special educational programs for nurses at all levels, active or inactive.

2. Provided consultive services to the Manitoba Hospital Survey Board for a



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unique and very valuable study of the province's needs in regard to health services.

3. Formed a joint committee with the Associated Hospitals of Manitoba for the discussion of mutual problems related to nursing service and working conditions for nurses.

New Brunswick

1. Assisted the University of New Brunswick school of nursing with arrangements for refresher courses as part of the continuing educational program.

2. Compiled a list of agencies concerned with patient care and designed a health referral form for use by hospitals and other agencies as an aid to continuity of care.

3. Through the efforts of small groups, is studying the impact of the hospital insurance scheme upon nursing.

Newfoundland

1. Undertook a revision of the system of registration examinations.

2. Is conducting a statistical survey of all nurses within the province.

3. Arranged for an institute on ward administration, a workshop on the implementation of the nursing curriculum in clinical fields, and a refresher course on several subjects of current nursing interest.

Nova Scotia

1. Anticipated the appointment of a nurse consultant to the Hospital Insurance Commission in the near future.

2. Sponsored or participated in several institutes.

3. Increased the annual registration fee.

Ontario

1. Increased the annual registration fee for active members.

2. Completed a study of registration examination methods in order to determine the type best suited to the province and the costs of a revision of procedure.

3. Continued with a survey of professional nursing registries for the purpose of assessing services, structure and operation.

4. Carried out an extensive conference program co-sponsored by the Ontario Hospital Association and the Ontario Medical Association and with the cooperation of the Ontario Hospital Services Commission.

5. Worked on a curriculum for a two-year basic course in nursing.

Prince Edward Island

1. Implemented its Nursing Assistants Act by developing a Central School for Nursing Assistants; by providing the means of licensure.

2. Conducted a workshop to finalize recommendations for a provincial minimum curriculum.

3. Presented further requests for the appointment of a nurse consultant to the Hospital Services Commission.

Quebec

1. Increased the annual licensure fee.

2. Is working on amendments to its Act which are related to the status of nursing assistants and male nurses.

3. Provided assistance to an increasing number of nursing students from other countries such as Cambodia and Viet Nam. French Canada is the only place where nationals from certain countries can obtain advanced nursing education.

4. Supervised translation into French of a text on obstetrics for nurses.

5. Made psychiatric nursing a prerequisite for registration.

6. Is presently conducting a study of the cost of nursing education.

7. Studied educational entrance requirements to schools of nursing and the qualifications of students presently entering. A problem exists in regard to raising present standards since so few schools offer basic education beyond Grade XI.

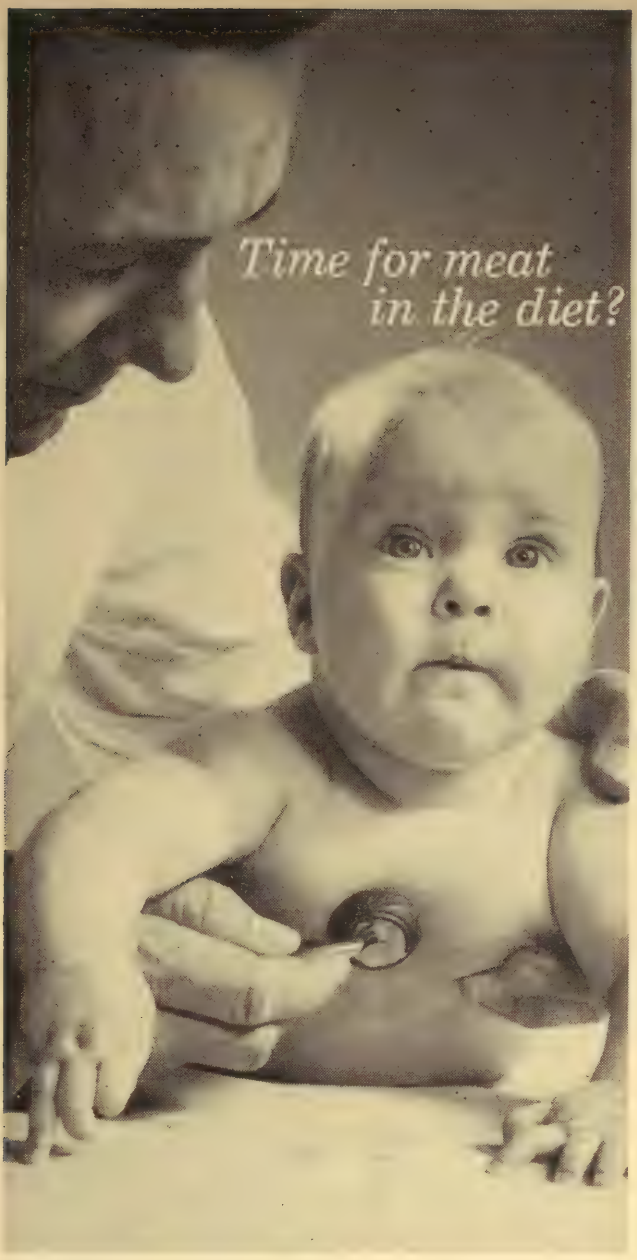
Saskatchewan

1. Along with the Saskatchewan Hospital Association and the provincial College of Physicians and Surgeons, approved the administration of intravenous solutions by nurses.

2. Moved into its own new office building.

3. Is studying the legal implications in private nursing and the possibility of a group coverage policy in respect to liability for malpractice, compensation for damage to personal property and loss of employment opportunities.

4. Revised the nursing assistant curriculum and extended the course from 9 to 12 months.



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The Implications for Nursing in Organized Home Care Programs

Introduction: It is apparent that nationally there is an awareness of and a growing interest in development of home care plans, as evidenced by:

1. The studies being made by various community agencies.
2. Provision of public funds for pilot home care programs.
3. The establishment of home care and liaison programs.
4. The impetus of a broader concept of rehabilitation.

The Committee on Nursing Service of the CNA accepted the following definition of home care plans:

> Those organized programs having centralized responsibility for the administration and coordination of services to patients (in their homes) and for providing at least the minimum of medical, nursing and social services.*

The Committee believes that:

1. The needs of selected patients can best be met by this type of program,
2. the expansion of home care programs will have considerable impact on nursing services and nursing education.

Implications for the Nursing Profession

If this new concept of care is to be realized, the nursing profession has a responsibility to help prepare all its members for their role since nursing is an integral part of such a program.

Before such a program can be developed, nurses, along with other members of the health team, will need to examine the resources available in the community, particularly nursing needs and resources, and plan for additional resources as required.

The public will need to know and to understand what this service offers and nurses will have to take part in interpreting this need.

Nurses need to recognize that hospital care may be only a relatively short part of the total length of care and that the hospitals is only one of many agencies contributing to the health and welfare of its citizens.

A close liaison between members of many professions is essential. Nurses will need to be prepared to interpret nursing and the nursing needs of individual patients to their co-workers.

The members of the nursing profession should recognize the importance of their status as members of the community and their responsibility to participate in community activities as citizens with special preparation.

The concept of nursing is broadening as a result of social and medical changes and the nursing profession has a responsibility to develop a clear statement of the philosophy of nursing and the role of the nurse in contemporary society.

Nursing education programs must be re-examined and adapted to meet the changing role of the nurse.

**Pilot Home Care Program — First Report.* Department of Health, Toronto, 1959.

We shall not be serving mankind well if we become obsessed with just the business of putting new satellites into orbit — so obsessed that we overlook the fact that we have some real problems left right here on earth. We need to put new ideas — and more of them — into orbit. And we must use every resource at our command to see that people everywhere achieve greater understanding of each other before it is too late.

— Dwight Eisenhower

Robert Laird Borden was born in **Grand Pré** in the Annapolis Valley of Nova Scotia. This is one of the best known onetime Acadian villages and boasts Evangeline Memorial Park with its collection of Acadian relics.

— Dorothy Duncan

* * *

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— Ogden Nash

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*Niedelman, M. L. and Bleier, A.; Jour. Ped., 37:5, 762, Nov. 1950
Fischer, C. C. and Lipschutz, A.; Am. Jour. Dis. Child, 89:5, 596, May 1955
Benson, R. A., et al: Arch. Ped., 73:250 - 8, July 1956

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TOWARD BETTER PATIENT CARE

The nursing staff of The Toronto Western Hospital had a most interesting experience in the form of a three-day workshop held in January of this year. As in any large, growing institution with the inevitable changing of personnel, one of the main problems facing the nursing staff of this hospital was the lack of communication, not only among themselves, but with other departments. It was felt that this lack of communication was bound to have an adverse effect on satisfactory relations with the patient.

As early as the spring of 1959 this workshop had been under consideration. However, it was not until June that five members of the staff were approached to form the Planning Committee. Members of this committee were drawn from the departments of nursing service and nursing education. Four months of careful planning preceded the event. During this time the planning committee met frequently despite the fact that some members were on different tours of duty. Once the initial plans were prepared a social convener and a publicity agent were appointed from the nursing staff. When the dates for the workshop had been decided, the department of nursing education cooperated by rearranging students' lectures and clinical experience to enable the clinical instructors to attend. Nursing service arranged for adequate coverage of all departments during the absence of the head nurses. A month prior to the event a letter of invitation with a list of suggested reference reading was sent to all those who were expected to attend. Seven members of the staff were approached to act in the capacity of group leaders. In choosing the members of the work groups an attempt was made to have persons from different departments represented. The hospital staff was made aware of the project by eye-catching posters in strategic positions. Personnel from other departments were invited to attend the open sessions. Many took advantage of this invitation.

The workshop consisted of small discussion groups and at least one main general session daily. In planning every effort was made to ensure a relaxed and informal atmosphere. To do this the hospital administration very generously gave all members in attendance three complete days away from their various departments. The participants numbered approximately 50 in all. This included the entire head nurse and clinical instructor group, with administrative supervisors and general staff nurses attending when duties permitted. Miss Carol Adams, the nursing consultant for education and service, RNAO, acted as an observer. Her assistance in the day-to-day evaluation was much appreciated. Everyone participating wore street dress; smoking was permitted in the small work groups; coffee and tea were served morning and afternoon, in a further effort to achieve informality. By these means it was hoped to promote freedom to express opinions, to state existing problems, and to suggest methods for improvement.

On the first day the participants registered as at any conference. They received monogrammed plastic portfolios, containing pertinent literature, bibliographies and name tags with colored ribbons attached. These tags were worn to differentiate the discussion groups. In all there were seven groups of seven members.

After a brief introduction, the content of the first general session was provided by the director of nursing, Miss Grace Paterson. She outlined the administrative structure of the hospital and nursing department. The associate director of nursing education. Miss Audrey Shiach, presented the philosophy and curriculum of the school of nursing. The information given by these speakers was new to many, and an excellent review of recent changes for older members of staff. It proved valuable in clearing up misunderstandings that may have existed between nursing service and nursing education as to their respective roles, and provided conversational material for the first group discussion when all members were unsure of the best way to proceed.

As team nursing had been in practice at Toronto Western Hospital since 1950, and problems still existed in this area, it was felt that a review was indicated. The general session for the second day was planned around this theme. A panel consisting of representatives of the nursing team from supervisor to nursing assistant level was asked to express opinions as to how effective team nursing was in meeting the needs of the patient, and promoting job satisfaction. This evoked much discussion and many helpful

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This report was prepared by the members of the committee who planned the workshop under the chairmanship of Mary T. Hickey.



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suggestions as to how improvements could be made. Another encouraging aspect was the interest aroused in the areas where team nursing is not in effect. Several of the head nurses on private floors are presently making plans to institute team nursing, as they have been convinced that it improves patient care.

One of the objectives of the workshop was to improve interpersonal relationships in order to improve patient care. With this in mind, Dr. Karl Bernhardt, professor of psychology at the University of Toronto, was invited to speak on the importance of interpersonal relations. Dr. Bernhardt pointed out that, in a hospital too much emphasis may be placed on efficiency to the detriment of the patients' welfare. He continued by stating that a basic theory in getting along with others, is to move outside our egocentric thoughts. One must have a genuine interest in the individual as a person and establish a feeling of empathy.

The leaders of the work groups had met with the planning committee one week prior to the workshop. At this time their role as leaders was discussed, demonstrated by use of films, and by the provision of reading assignments. The topic of discussion in the group sessions was left entirely to the members. They were free to discuss what they felt was important to them as a group. All members remained in the same group for the three days, so that there was continuity of thought and discussion. At the end of each day the group leaders met with the planning committee to discuss progress and to present a summary of their discussions.

At the end of the third day, a final general session was held. An attempt was made to highlight the common problems of all groups. The director of nursing, the associate director of nursing education, and the medical superintendent were invited to attend. Many recommendations were directed to the hospital administration. It was interesting to note that the majority of these recommendations sought, in some manner and however indirectly, to improve care to patients and increase the job satisfaction of the graduate nurse. The workshop concluded with a dinner organized by the social convener and attended by the majority of the participants.

There are numerous signs that the workshop has had immediate effects. Although many of the recommendations have not as yet been implemented, the sharing of ideas goes on. The knowledge that we are not alone with our problems has resulted in a better understanding of each other, and has made us aware of the need for continual self-evaluation. Another obvious result is the closer understanding that has been created between clinical instructors and head nurses. These two groups are planning to hold regular meetings to discuss and attempt to solve problems together. The participants have expressed general appreciation of the opportunity to evaluate their performance, and to seek methods of improvement.

It was unanimously decided that a post-workshop meeting will be held in order to assess the value of the workshop in terms of progress that has been made toward promoting "Better Patient Care."

Creative clinical work and significant laboratory research in the areas of language disorders and stuttering are revealed in two new publications. Written for professional workers, a long-term study of children with delayed speech and language is reported by Nancy E. Wood, Ph. D. director, Language Disorders, Cleveland Hearing and Speech Centers. Scientific findings on the problem of stuttering are provided by Oliver Bloodstein, Ph.D. of Brooklyn College.

Language Disorders in Children which sells for 50 cents and The Handbook on Stuttering for Professional Workers for $1.00, may be obtained by writing to: Publications Office, National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois.

One of the loveliest sites in Cape Breton is the view from Alexander Graham Bell's "beautiful hill." Located in **Baddeck,** it overlooks the shimmering waters of the **Bras d'Or Lakes** adorned with verdant islands. — Dorothy Duncan

* * *

In those vernal seasons of the year, when the air is calm and pleasant, it were an injury and sulleness against Nature not to go out and see her riches, and partake in her rejoicing with heaven and earth.

— Milton

* * *

I don't complain of Betsey, or any of her acts,

Exceptin' when we've quarreled, and told each other facts. — Will Carleton



Her mother might help, but

SHE'D RATHER TALK TO YOU ABOUT PIMPLES

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CANADA'S LARGEST-SELLING PIMPLE MEDICATION . . . BECAUSE IT REALLY WORKS

The Treatment of Deep-seated Ulcers by Exposure to Air and the Use of Oxygen

GEORGE J. GREGG, R.N., B.T.A.

Something new has been added in the treatment of recalcitrant ulcers.

AT A HEAD NURSES' MEETING Dr. G. A. Clark, who had recently returned from a trip to Germany where he studied the treatment of ischemic extremities by the injection of oxygen into the arteries, gave us an interesting talk. Subsequently, in a discussion between the ward doctor and nursing staff, it was decided to try the effects of oxygen applied locally to open areas, in selected patients.

The ward in question is one where patients who develop staphylococcal infection are isolated. Quite often our patients are aged or chronically ill, and since "staph." infections are prone to develop on areas that are subject to pressure, *i.e.*, shoulder blades, hips, sacrum, etc., one of our major problems is healing the ulcers left by furuncles and carbuncles in these areas. We were already treating these cases by exposure to air and have obtained quite good results. However, with the use of oxygen as well, healing appears to be accelerated.

Method of Treatment

A soft rubber catheter is taped, using adhesive, in a central position on the area to be treated. An abdominal pad soaked in saline is placed firmly over the area. The catheter is connected, via a length of rubber tubing, to the flow meter of an oxygen cylinder. Oxygen is run through at 7 litres per minute for 30 minutes twice a day. We found that by using "Y" glass connections and increasing the oxygen flow to 15 litres, it was possible to treat two areas each on two patients at the same time. Several orderlies have now been instructed in the technique and, under supervision, one orderly can set up, carry out treatment and clear away in about 45 minutes.

Another method tried, and one that appears useful in treating a single ulcer is to strap a plastic face mask over the area to be treated. The use of oxygen is of course a considerable fire hazard, and it has been found necessary to group patients and special equipment in a separate room. Usual precautions are taken to eliminate accidents.

Two patients were selected for a practical demonstration of this form of treatment. Both had severe contractures of the legs and had been nursed on Stryker frames for a considerable period of time.

1. A male, age 36, suffering from disseminated sclerosis, with large ulcers on knee, hip and sacral areas.
2. A male, age 45, a post-spinal injury, paraplegic.

Progress

In the first patient, the areas treated showed some response on the second day. At the end of a two-month period the knee ulcer, about 2½" in diameter, closed to the size of a nickel, a short period compared with the length of time the ulcer had been present.

The deep ulcer on the hip of the other patient responded very well also, healing up from the bottom and becoming much smaller in diameter.

The first effects of the oxygen were the formation of multiple, bright red granulations, followed by a pronounced ridge of new tissue which grew up from the middle of the ulcerated area. Healing appeared to progress from the ridge outward and from the edges inward. Oxygen being devoid of humidity also has a marked drying effect, which is desirable. After treatments a dry dressing only is applied. Whenever possible, both day and night dressings are removed and the areas are exposed to the air.

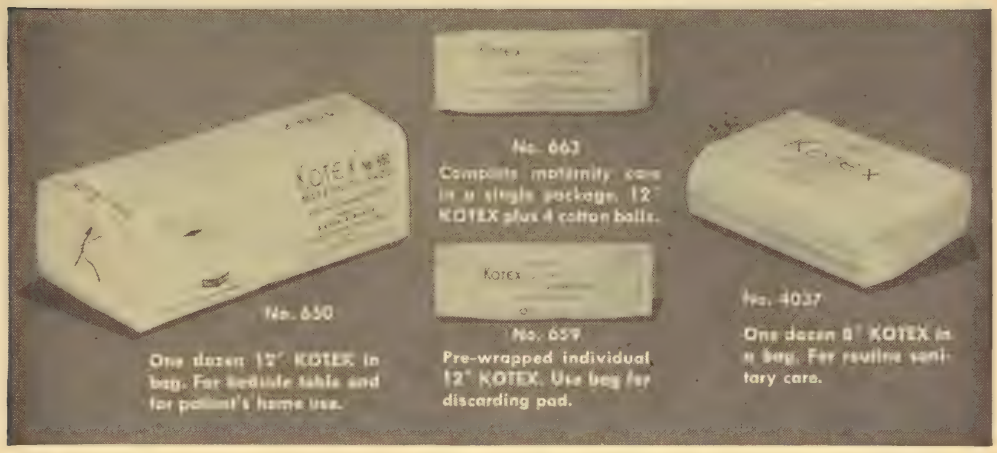
These oxygen treatments supplemented by exposure to the air, daily saline baths, a balanced diet, and 3-hourly back care routine, day and night, appear to be showing results.

Mr. Gregg is on the staff of Westminster Hospital, (D.V.A.) London, Ont.

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In Memoriam

Leita Vail Allingham, a graduate of the Minnesota General Hospital, died recently in Ottawa, at the age of 61. A native of Saint John, New Brunswick, she had nursed in Detroit and had been employed with the Winnipeg Free Press. For several years, Miss Allingham was law librarian with the Parliamentary Library at Ottawa.

* * *

Hélène Beaudet, a graduate of Hotel Dieu Hospital, Montreal, in 1919, died recently. She had engaged in private nursing.

* * *

Angeline Blanchet, a 1917 graduate of Notre Dame Hospital, Montreal, died recently. Her professional career was spent in public health nursing.

* * *

Beatrice (Nairn) Darker, a graduate of Grace Hospital in 1920 died at her home in Toronto on November 26, 1959.

* * *

Alice Eleanor (Johnson) Dawe, who graduated from St. Paul's Hospital, Vancouver, in 1917, died there on February 22, 1960, after a short illness.

Throughout her married life she maintained close contact with St. Paul's, holding several executive positions in the Alumnae Association. During World War I she was awarded a citation for her work with the Red Cross and returned to nursing during World War II. She accumulated information and edited the Jubilee Book published in 1957 for the anniversary of St. Paul's school of nursing.

* * *

Agnes (Curr) Girvan, a graduate in 1950 of the Toronto Western Hospital died suddenly at her home in Toronto on February 13, 1960. Mrs. Girvan had worked in Santa Monica, California before returning to T.W.H. five years ago as clinical instructor, a post she held at the time of her death.

* * *

Mabel L. Partridge who graduated from the Hospital for Sick Children in Toronto in 1914, died on February 7, 1960. Miss Partridge joined the staff of the Haldimand School Medical Inspection Unit in 1923 and became senior nurse of the Haldimand County School Health Service in 1950, a position she held for ten years.

Euphemia (Wylie) Huston, a graduate of the Toronto Western Hospital in 1904, died in Manilla, Ont. on November 26, 1959.

* * *

Amy E. Lord, a native of Tryon, P.E.I., was accidently killed in Edmonton, Alta. on February 27, 1960. A graduate of the Royal Alexandra Hospital in Edmonton, Miss Lord served as a nurse with the Edmonton Public School Board and the city health for 20 years. Following her retirement in 1957, she became assistant to the director of a private duty registry in Edmonton.

* * *

Martha McBride who graduated from St. Joseph's Hospital, Victoria, B.C. in 1911, died on January 7, 1960 in that city. Miss McBride, who was born in Ireland, came to Victoria in 1900. During World War I she served overseas with the Canadian Medical Corps, was twice mentioned in despatches and during service at Salonika was awarded the Royal Red Cross.

Miss McBride had held positions at the military hospital, Craigdarrach Castle, St. Joseph's Hospital, and Royal Jubilee Hospital.

* * *

Mary Rosalie Osborne, a graduate of Central Maine General Hospital in 1913, died at her home in Milltown, New Brunswick, on January 16, 1960. Miss Osborne had held administrative positions in hospitals in Maine, Ohio, and New York and was on the teaching staff of her alma mater at the time of her retirement. She was one of the first nurses to respond to the call for nurses at the time of the Halifax explosion in 1917.

* * *

Eileen (Snowden) Ramsay, a public health nurse in the Cariboo Health Unit, Quesnel, B.C., died on February 9, 1960. Mrs. Ramsay was a graduate of the Jubilee Hospital in Victoria and joined the Provincial Public Health Service in 1937.

* * *

Maud Whitehead, who retired in Vancouver 30 years ago died at the age of 87 in St. Vincent's Hospital on December 30, 1959. Miss Whitehead nursed in Vancouver before going to Hawaii, where she had served as matron of the hospital at Hilo for several years prior to her retirement.

Halifax County produces more than 500 barrels of clams annually. — Dorothy Duncan

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the quick refreshment and lift in ice-cold Coca-Cola.

Rehabilitation Nursing Seminars

A SEMINAR ON REHABILITATION nursing, initiated by the provincial coordinator of rehabilitation, was held in Saskatoon November 18 - 20, 1959, and in Regina November 23 - 25. Miss Laura Hegstad, nursing consultant in Chronic Disease and Rehabilitation, Minnesota Department of Health, was the guest lecturer on both occasions.

The chairmanship of the Saskatoon seminar was shared by Hazel Keeler, director, and Dorothy Hibbert, assistant professor, of the School of Nursing, University of Saskatchewan and Caroline Dauk, University Hospital. Participating in the program were Dr. A. L. Swanson, director, University Hospital; Dr. T. E. Hunt, professor and director of the Department of Rehabilitation Medicine, University Hospital; Jean MacGregor, physiotherapist; Lois Hunter, speech therapist and M. Brody, occupational therapist.

In Regina, Mary Earnshaw, nursing consultant, Child Health Division, Department of Public Health, presided as chairman. Dr. A. F. Huston, acting director, Regina Physical Restoration Centre, gave generously of his time, both through lectures and tours. Other participants were Dr. G. A. Roeher, provincial coordinator of rehabilitation; Mr. W. J. Dockerty and Mr. W. J. Jeffers, physiotherapists; Mrs. M. W. Hunter, speech therapist; F. E. Bryce and C. Gray, occupational therapists. This seminar was held at the Physical Restoration Centre.

Rehabilitation is the process of assisting the individual with a handicap to realize his potentialities and goal. It is also a process of teaching the patient to make the maximum use of the capacities that he has left following disease or injury, to the point where he can live a full life. The more common and all too familiar types of incapacitating diseases and injuries were reviewed. It was learned that rehabilitation begins early, with all members of the team participating. We must learn to work *with* the patient and not *on* him. Prerequisites for this care are infinite patience, learning to be a good listener to patient needs and wants, and repetitive teaching with a realistic approach in simple acts such as grooming (e.g. insertion of dentures or brushing teeth, adjusting eye glasses, combing hair, applying a brace or putting on a shoe.) We must learn to stress what is *left,* not what is *lost.*

The Regina centre was planned to meet the varying needs of those of all age groups who suddenly found themselves facing their future with a handicap of great magnitude. The thinking of those in nursing must be geared to newer concepts of what constitutes good nursing care and to more skilful techniques in the application of knowledge.

The delegates were most appreciative of the effort made by the patients to serve afternoon tea from trays fitted to their wheelchairs and readily adapted to this use. This demonstration of achievement and the smiling faces made it a most pleasant interlude. There was also a display of specially made clothing (wrap-around rather than pullover) to facilitate and improve the grooming of the handicapped.

FRANCES COPEMAN,
Assistant Director Nursing Services,
Providence Hospital,
Moose Jaw, Saskatchewan.

Patients with deep-lying leg veins obstructed by clots, improved faster and suffered fewer complications when fibrinolysin (plasmin) was added to standard treatment, reports Dr. Kenneth Moser of Washington.

Animal studies done at the Sloan-Ketterling Institute, New York, indicated that giving fibrinolysin soon after an experimentally-produced heart attack seemed to flush away a sludge of microscopic clots in the smallest coronary vessels. Damage to the heart muscle has been reduced by as much as 25 to 50 per cent.

Newsletter, American Heart Association

The women of the village of **Cheticamp, N.S.,** thread the wool taken from their own sheep into patterns and color schemes to make up the most exquisite hand-hooked rugs. — DOROTHY DUNCAN

* * *

The **Cabot Trail** is a circular motor road that outlines the most eastern projection of land in Canada, **Cape Breton Island.**

— DOROTHY DUNCAN

* * *

No economic equality can survive the working of biological inequality.

— HERBERT HOOVER

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The crucial time for any meeting is the planning session. There are six key individuals who should help to plan any meetings:

1. Ideas — a creative person who makes suggestions rapidly and can be counted upon for new approaches.
2. Practical person -- someone who can test ideas, analyze for flaws and weigh ideas against his experience.
3. Organizer — the individual who can get things done after decisions are made. He follows through — he must know how to accept and discharge responsibilities.
4. Content — this individual supplies the topics for the meeting.
5. Public Relations — gives ideas on how to "sell" the meeting.
6. Interview Expert — discovers what the audience wants to experience at the meeting; what bothers individuals, their weaknesses and their strong points.

When the planning session includes these six talents, all important areas are covered. These individuals need to understand in advance what their role are so that they can prepare to be of real assistance.

Sales Meetings, July, 1957

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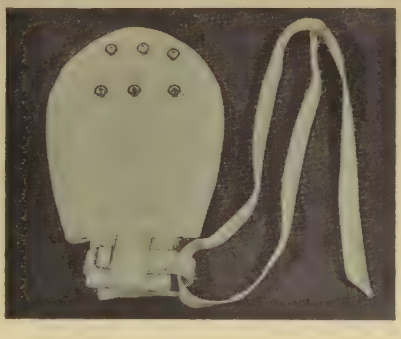
1960 is the Seventieth Anniversary of our School of Nursing and the Fortieth Anniversary of our Nurses Alumnae Association. As part of the Biennial Convention, we hope to meet many of our graduates at our buffet supper to be held in Nurses' Residence on June 19, 1960.

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Book Review

Textbook of Pharmacology for Nurses by Margene O. Faddis, R.N., M.A. and Joseph M. Hayman, Jr., B.A., M.D. 451 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 5th ed. 1959. Price $5.50.

Reviewed by Miss Jean Brewer, Instructor, Misericordia Hospital, Winnipeg.

The objectives of this text, as in previous editions, are to help the nurse assume the responsibilities inherent in the administration of drugs. In this revised edition, there have been additions of some of the newer drugs and also some changes made toward simplification of increasingly difficult content.

In dealing with the preparation of dosages for hypodermic administration, the attempt to simplify formulas appears to have made them more complicated giving extra room for error. The illustrations showing the dissolving of tablets in a spoon in the preparation of a hypodermic injection are good although this has become an obsolete method in many hospitals.

The illustrations of the areas of injection are very good and illustrate clearly why injections are to be given in the respective sites. More and more today, the responsibility for intravenous fluid administration is being placed on the nurse, and it is interesting to see that a section on intravenous infusions has been included in this text.

The special points for nurses are very helpful. They bring to the student's attention specific factors concerning that particular drug or group of drugs.

In the section on insulin, the all-important subject of teaching the patient how to give his own insulin and the care of the syringe and other equipment, is very well explained.

The problem of self-medication is becoming a serious one and some of the reasons for this are given in a subsequent chapter.

Finally, at the end of the text, there is a supplement on Canadian Drug Legislation by F. Norman Hughes, Phm.B., B.S. in Phar., M.A., LL.D., and Isobel E. Stauffer, B.Sc., (Pharm.), M.S., giving the student compact information regarding the specific statutes and regulations of drug legislation in Canada. Student nurses and instructors alike, would find this textbook a help to them in their study of pharmacology.

We do not count a man's years, until he has nothing else to count. — Emerson

A man must not swallow more beliefs than he can digest. — Havelock Ellis

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Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

Instructor, Psychiatric Clinical (to teach affiliating students in 8-wk. program) 1500-bed active treatment hospital conducting an accredited school of nursing. Salary range $4,320 to $5,160 per annum, 40-hr. wk., civil service holiday, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply stating qualifications & experience to: Superintendent of Nurses, Provincial Mental Hospital, Department of Public Health, Ponoka, Alberta.

Matron for new one (1) storey 20-bed Municipal Hospital with nurses' residence. Please state qualifications, experience, salary, references & when available. Apply: Secretary-Treasurer, Bow Island Municipal Hospital, Bow Island, Alberta.

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Registered General Duty Nurses for busy 45-bed hospital with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr.wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

Registered Staff Nurses (2) immediately: for 12-bed hospital close to Banff. Salary $250 per mo. less $30 for room & board. Rotating 8-hr. shifts, 40-hr. wk., 4-wk. vacation with pay after 1-yr. service. Apply: Matron, Municipal Hospital, Canmore, Alberta.

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General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

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General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

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Clinical Instructress (with Degree or Certificate), **Operating Room Nurses** (Postgraduate Training), **General Duty Nurses** for 450-bed hospital, B.C. registration required. Salaries & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

Instructor (Senior) in Biological Sciences with experience in clinical areas and/or in teaching Anatomy & Physiology — salary based on experience & qualifications. Enrolment 350 students. Apply to: Director of Nursing, St. Paul's Hospital, School of Nursing, Vancouver, British Columbia.

Registered Nurses (3) for 30-bed hospital. Starting salary $285 per mo. with $10 yearly increment. Past service recognized for salary purposes. Board & room $40, 1½ day sick leave per mo. 40-hr. wk. 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

Registered Nurses (3) immediately for present 39-bed hospital — new 50-bed hospital & new nurses' residence under construction. Salary $285 per mo. with annual increments if B.C. registered; $270 per mo. non B.C. registered. 1-mo. annual vacation, sick leave benefits. Board & room $50 per mo. Please address all replies to: Director of Nursing, Terrace & District Hospital, P.O. Box 1297, Terrace, British Columbia.

Registered Nurses (3) for 30-bed hospital in Central B.C. on the Jasper-Prince Rupert Highway, 70-mi. from Prince George. Salary $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Kindly apply giving qualifications & references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

General Duty Nurses for small active hospital. Salary $260 for unregistered, $275 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. **Nurses Aides** — with vocational training. Salary $177-$201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270 Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $280-$336. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric & General Duty Nurses (Position available immediately) for new modern 125-bed hospital & nurses' residence in the heart of British Columbia. Starting salary B.C.R.N. $285. For further particulars write: Nursing Supervisor, Prince George & District Hospital, Prince George, British Columbia.

Male Operating Room Nurses (Registered in British Columbia) ability to carry responsibilities of a circulating nurse essential. Experience preferred. Salary $285 - $342; differential for postgraduate work. 40-hr. wk., rotating shifts, no "call" work; 4-wk. annual vacation, cumulative sick time, health plan. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses (2). Salary: $285 per mo. Room, board & laundry: $40 per mo. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

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BENEFITS: Three weeks holidays, three weeks accumulative sick leave allowance annually with pay, excellent pension and group life insurance plans and other benefits.

APPLICATIONS: Forms and further information available at Public Service Commission, Legislative Bldg., Regina, Sask. Applicants should refer to File No. c/c 6200. This competition closes as soon as a qualified applicant is obtained.

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Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with semi-annual increments of $5.00-$305; 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

"STOP! IS THIS WHAT YOU ARE LOOKING FOR?" Applications are invited for positions on the permanent or "vacation relief" Staff of a 50-bed active hospital 35-mi. from Vancouver. R.N.A.B.C. Personnel Policies in effect. Apply to Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

MANITOBA

Matron for 35-bed General Hospital, in southern Manitoba. Duties to start immediately. Starting salary $350, room & board charged at $45 per mo., no charge for laundering separate residence, pleasant staff to work with. Apply: F. E. Dueck, Administrator, Altona District Hospital # 24, Box 660, Altona, Manitoba.

Registered Nurse (Immediately) for 10-bed hospital, with possibility of being Matron in the near future, if interested. Salary for R.N. $310 per mo. with increments of $5.00 every 6-mo. for 4 years. Matron's salary $370 per mo. with same increments. For further particulars apply to: Mrs. Sheila McEwan, Secretary, Birch River Medical Nursing Unit, Birch River, Manitoba.

Registered Nurses (2) Starting salary $295 per mo., new nurses' residence in hospital situated 100-mi. west of Winnipeg, Manitoba, on No. 2 Highway. Excellent staff policy in effect, & copies available upon request. Please send applications to: Miss Jean Simpson, Matron, Glenboro Medical Nursing Unit #16B, Glenboro, Manitoba.

Registered Nurses (2) for 20-bed hospital. Salary: $300 per mo. gross. 40-hr. wk. with 4 annual increments of $10. 3-wk. vacation with pay after 1 full yr. employment, 4-wk. after 2 full years. Sick leave, 1 day for each full mo. of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Apply: Matron or A.C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurse over 30 years with at least 5-yr. experience & some administrative ability to act as Matron for modern 60-bed hospital. Salary: $360 with increments. Good living quarters. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered Nurses for Swan River Valley Hospital. Salary: $280 with 4 semi-annual increments to $300. 44-hr. wk., 3, 8-hr. rotating shifts. 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Daily bus service to points — north, south, east & west. Local golf club, flying club, curling club; good swimming, fishing, skating, etc. Apply: Swan River Valley Hospital, Swan River, Manitoba.

Registered & Licensed Practical Nurse for General Duty. Gross monthly salary $310 for R.N., — $220 L.P., less $45 for full maintenance. Apply: John Hiscock, Secretary Treasurer, Medical Nursing Unit, Baldur, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses, min. $275 - max. $304 per mo. with $10 additional for evening duty; for Licenced Practical Nurse min. $208 - max. $230 per mo. 8-hr. duty (day, evening or night), 40-hr. wk. Must be registered or licensed in Manitoba. Apply in writing to: The Director of Nursing, Municipal Hospitals, Winnipeg 13, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NOVA SCOTIA

Operating Room Supervisor (Immediately) Starting salary $3,000 p.a., 40-hr. wk. Apply giving full particulars to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

Registered Nurses for 80-bed hospital, starting salary $220 with annual increments, living accommodation available. Apply: Director of Nursing, Highland View Hospital, Amherst, Nova Scotia.

Registered Nurses for night and **Obs. Supervisors (Immediately).** Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1-yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.



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ONTARIO

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Assistant to Director of Nursing Service to work afternoon & evening shifts rotating bi-weekly, 5-days per wk., in 100-bed active General Hospital. Excellent personnel policies & salary scale. Employer participation in pension plan. Personal interview will be arranged. Forward enquiries to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Floor Supervisor & General Duty Nurses for 50-bed hospital, 40-hr. wk., 8 statutory holidays, comfortable residence. Meaford is situated on Georgian Bay & is a tourist town. For further information apply to: Director of Nurses, General Hospital, Meaford, Ontario.

Registered Nurse as Superintendent (Immediately) for 30-bed hospital, stating previous experience & salary expected. Furnished 3 room apartment provided. Apply to: Secretary, Englehart & District Hospital Board, Box 609, Englehart, Ontario.

Female Superintendent for 30-bed modern hospital, located in the Town of Matheson — Staff 28. To be responsible for Supervision of Staff; and all phases of hospital operation — (except accounting). Separate suite of rooms for Superintendent — beautiful location. Duties to commence May 1, 1960. Please apply, stating age, qualifications & salary expected, to M. D. Kaye, Chairman of Board of Directors, Bingham Memorial Hospital, Matheson, Ontario. — Phone 375.

Instructor — School of Nursing. Are you a registered Nurse Instructor with a few year's experience? Would you like the opportunity of trying your own ideas in a smaller situation? If so, apply to the: Director of Nursing, Victoria Hospital, Renfrew, Ontario.

Clinical Instructor for the Plummer Memorial Public Hospital School of Nursing. Address applications to the: Administrator, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurse with experience in Central Supply for 382-bed active hospital. Good salary & fringe benefits available. Apply in writing to: Director of Nursing Service, Hotel Dieu of St. Joseph, Windsor, Ontario.

Registered Nurses for 100-bed active General Hospital. Good salary, personnel policies include 5-day work wk., 14-days paid sick leave accumulative, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan. Apply to: Director of Nursing. The Cottage Hospital, Pembroke, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

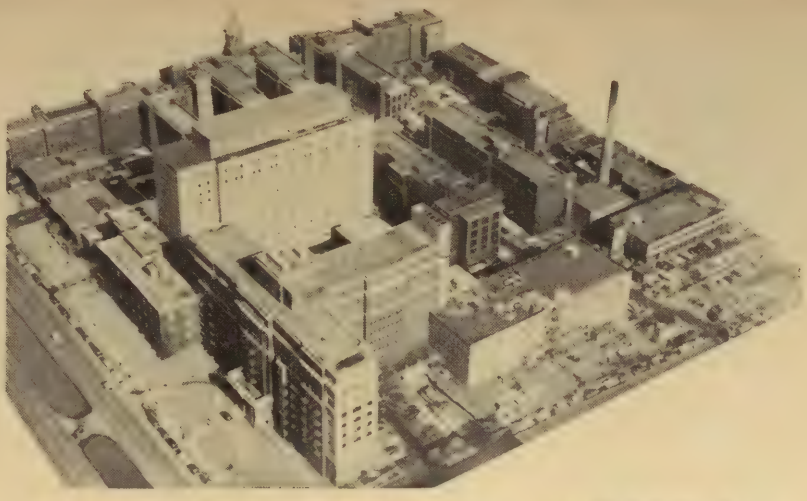
Registered Nurses for general duty nursing in all departments of hospital. Apply: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 58-bed hospital, North-Western Ontario tourist area town, midway Fort William & Winnipeg. Gross salary $285 per mo. with increments & consideration for past experience. Excellent personnel policies, pleasant working conditions. Single room residence accommodation. Apply: Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $270, 40-hr. wk., 14-days sick leave, 1-mo. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty on Surgical Floor in 163-bed Sanatorium. Good salary & personnel policies. Residence accommodation available. Apply: Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.



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Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

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Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for Obstetrics & Medical Floor. Gross salary $260 - $285 per mo. Differential salary for afternoon and nights. 40-hr. wk., 8 statutory holidays, 4-wk. vacation after 1-yr. service. Pension plan, sick leave cumulative. Apply: Director of Nursing, South Waterloo Memorial Hospital, Galt, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk., good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses for modern hospital, building expansion under way increasing to 100-beds this year. Starting salary $250 per mo., $215 for Graduates. 40-hr. wk., group life, accident & sickness insurance free to employees. Opportunities for advancement, pleasant community. Apply: Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered Staff Nurses for all departments (including Operating-Room); 5-day wk; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

Registered General Staff Nurses for all services, R.N.A.O. salary schedule, increments every 6-mo. 40-hr. wk., differential for evening & night duty. Excellent personnel policies & pension plan. Apply to the: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

General Duty Registered Nurses & Operating Room Nurse for new, well equipped modern 37-bed hospital. Excellent personnel policies. Apply: Superintendent, Kemptville District Hospital, Box 248, Kemptville, Ontario.

General Duty Registered Nurses for 74-bed General Hospital, starting salary for nurses currently registered in Ontario $275 per mo. Full maintenance $50 per mo. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 50-bed hospital. Salary $270, 5-day wk., summer & winter sports area. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses for modern 42-bed hospital. Starting salary: new graduates, $275; 1 or more year's experience, $285. Annual increments; shift differential bonus; Ontario registration necessary for maximum salaries. 40-hr. wk. Residence accommodation available. Apply to: Nursing Supervisor, General Hospital, P.O. Box 909, Sioux Lookout, Ont.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

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Qualified by professional training and personality to provide administrative guidance and high quality bedside care.

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McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurses (qualified). Generalized program includes some bedside nursing. Salary $3,200-$4,250, annual increment $150, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses (Kitchener Department of Health, September 1960). For further information write: Miss Olga Friesen, Department of Health, 9 Ahrens Street East, Kitchener, Ontario.

Public Health Nurses for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500-$4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave- 1½-days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Uniform allowance - Initial $200, yearly $75. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (2) Bilingual for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500 - $4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave- 1½-days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Nurses (Bilingual) having a public health certificate for a Health Unit in rural Ontario. Minimum salary $3,300, 5-day wk., cars available or allowance for own car. Cumulative sick leave. For further information write to: Dr. R. G. Grenon, Director, Prescott & Russell Health Unit, Hawkesbury, Ontario.

Nurses for Nurses' Technician Team (Intravenous & Intramuscular Therapy, Venepuncture etc.). 40-hr. wk., shift work. Good personnel policies. Apply: Assistant Superintendent, Ottawa Civic Hospital, Ottawa, Ontario.

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Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

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Director of Nurses for Jewish Home for aged with advanced professional standards. Staff includes medical director, psychiatrist, case worker, group worker, occupational therapist, physiotherapist, chiropodist, dentist. We have cooperative relationship with fine General Hospital. Excellent salary & conditions. Address: 4373 Esplanade Avenue, Montreal, Quebec. Phone: VI. 5-2105.

Director of Nursing for modern non-profit, J.C.A.H. Accredited 125-bed General Hospital. Downriver area, Detroit, Michigan. $8,000 - $10,000 yearly, depending on qualifications. Liberal personnel policies, unusual opportunity. Approved residency program; staff, board certified specialists. Progressive expanding organization. Emphasis on postgraduate education. Experience in Nursing Service, Supervision & Administration preferred; Master's or Bachelor's Degree required. Forward complete details to Box K, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in the Montreal area). Excellent personnel policies, working conditions, and accommodation in the Nurses' Home. Apply to: Box 1000, Ste. Agathe des Monts, Que.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurses for Tuberculosis Hospital 60-mi. north of Montreal. Excellent personnel policies. Apply to: The Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

SASKATCHEWAN

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses for new 18-bed hospital with new nurses' residence opening May 1960. We have 4 Doctors on our Medical Staff also Canadian Mental Health Services & Canadian Arthritis & Rheumatism Services. 30 days annual vacation, this includes statutory holidays. Starting salary $260 per mo. which shall be increased in January 1960. Apply: John Uhryn, Administrator, Union Hospital, Davidson, Saskatchewan.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



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(2) Directors of Nursing in Hospitals: up to $5,400 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $4,050 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

- Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three week's annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.
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(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

General Duty Nurses (2) Immediately; for modern 22-bed hospital located in a pleasant active community. Basic salary $280 per mo., if registered in Saskatchewan. 40-hr. work wk., pension plan available, modern residence accommodation with T.V. available at $34.50 per mo. For further information & application forms apply to: J. R. Huckstep, Secretary-Manager, Union Hospital, Box 70, Shellbrook, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital in picturesque mountain foothills, no smog or rain. Starting salary $337-$395 plus normal increases, 3-wk. vacation etc., Leisurely living in home-like congeniality, near L.A., San Diego, Las Vegas, & 8-mi. near historic Mexico. Send for descriptive letter to: Mr. L. J. Lonni, P.O. Box 1771, El Centro, California.

Supervisory or Staff Position: according to your qualifications. (Come to Sunny California). This 500-bed accredited teaching hospital offers unusual opportunities for growth. Excellent starting salary & increment program. Holidays — sick leave — vacations & Group Insurance. We feel sure we will be able to place you, we know you will like being associated with this modern progressive hospital that is located in the heart of the greater Los Angeles metropolitan area. Apply: Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn., O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write: Personnel Office, Sutter Community Hospitals, 2820 - L Street, Sacramento, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered General Duty Nurses (2) for small General Hospital. Salary $375 per month. For information write: Box 336, Dos Palos, California or phone Express 2-3266 collect.

General Duty Nurses (4) for new modern hospital. Starting salary $320 per mo., 40-hr-wk., differential for 3-11 & 11-7. Paid vacation after 1-yr. of service, sick leave & holidays. Apply: Personnel Director, Mercy Hospital, Merced, California.

Attention! General Duty Nurses 400-bed County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, 11-pd. holidays, pd. sick leave, retirement plan & social security. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of General Hospital, Tulare, California.

Staff Nurses for 200-bed General Hospital; heart of Los Angeles cultural & educational center. **General Duty:** $335 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays 12 day sick leave. Cotton uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools. California license obtainable immediately. Promotions made from staff whenever feasible. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South, St. Louis Street, Los Angeles 23, California.

THE ROYAL ALEXANDRA HOSPITAL

EDMONTON, ALBERTA

Requires

General Duty Nurses for Medical, Surgical, Obstetrical and Pediatric Services and for the Operating Room.

Minimum salary $270 per mo. with Alberta Registration.

Good personnel policies.

Apply to:

DIRECTOR OF NURSING,
ROYAL ALEXANDRA HOSPITAL,
EDMONTON, ALBERTA.

KINGSTON GENERAL HOSPITAL

requires

Operating Room Supervisor

Assistant evening and night Supervisors

Operating Room Head Nurse
for:
Neurosurgery, Ophthalmology, Ear, Nose and Throat surgery.

General Duty
for:
O.R., Medical, Surgical Floors and Intensive Care Unit
(male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants

For full details relating to hours, vacations and benefits, apply to:

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QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

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You will deal directly with children, their parents and service club members.

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Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Operating Room Nurses; Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (½) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses for 90-bed accredited hospital. Top salary, excellent benefits, good personnel policies, opportunities for promotion. Apply: Administrator, Sidney A. Sumby Hospital, 234 Visger Road, River Rouge 18, Michigan.

Operating Room Supervisor for 88-bed modern JCAH General Hospital. Minimum salary $335 based on qualifications, $40 call pay. Liberal personnel policies. College town 30,000, 85% sunshine belt, dry mild all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

General Staff & Operating Room Nurses for 88-bed modern JCAH General Hospital. Starting salary $300; $20 differential evening & night; $40 O.R. call, 40-hr. wk. Liberal personnel policies. College town 30,000; 85% sunshine belt, dry mild all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces. New Mexico.

Registered Nurses for 278-bed fully accredited hospital with all services, incl. Starting salary $350-$375 per mo., ICU Retirement Plan, paid insurance, & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

Graduate Staff & Operating Room Nurses for 225-bed General Hospital, near New York City. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, New York.

Graduate Professional Nurse, trained in Pediatrics. Hospital operated under the direction of the Episcopal Diocese of Albany. Nurse must be able to accept responsibility & supervise welfare of small children & direct students in Child Care. All maintenance, cardinal holidays, one month paid vacation. Write Miss Lona F. Bartlett, Superintendent, St. Margaret's House & Hospital for Babies, 100 New Scotland Avenue, Albany, New York.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

EDUCATIONAL DIRECTOR
FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required for September 1960 to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL, REGENT STREET SOUTH, SUDBURY, ONTARIO.

VICTORIAN ORDER OF NURSES FOR CANADA

has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
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Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

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ACTIVE, 200-BED, FULLY ACCREDITED.

Requires staff for the following positions:

Assistant Supervisor Operating Room —
Postgraduate study in operating room supervision and management.

GENERAL STAFF NURSES
CERTIFIED NURSING ASSISTANTS

Excellent salary and personnel policies
Additional salary paid for postgraduate study in specialty.

For further information apply to:

DIRECTOR OF NURSING, GENERAL HOSPITAL, GUELPH, ONTARIO.

UNIVERSITY HOSPITAL
SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL, SASKATOON, SASKATCHEWAN

SASKATCHEWAN COUNCIL for CRIPPLED CHILDREN and ADULTS

has immediate opening for

ASSISTANT COMMUNITY SERVICES SUPERVISOR

Qualifications: Public Health Nurse training, preferably with field work experience.

Duties Organization and direction of mobile rehabilitation and treatment clinics; assisting in direction of summer camps for the handicapped; co-ordination and development of branch, parent group, and community recreation programs. Travelling involved (transportation arranged).

Salary: $4,000 to $4,800 (according to qualifications) plus usual staff benefits.

Apply: **Executive Director, 1410 Kilburn Avenue, Saskatoon.**

Graduate Nurses interested in living in "Golden Triangle" metropolitan area with advantages of educational, cultural, civic, social activities, Medical teaching General Hospital, adjacent campus University of Pittsburgh. Interesting, challenging positions, liberal personnel benefits & excellent working conditions. Low cost attractive housing facilities available. Interested applicants write: Director of Nursing, Montifiore Hospital, 3459-5th. Avenue, Pittsburgh 13, Pennsylvania.

Staff Nurses (Intensive Care Unit) for real bedside nursing. Take advantage of this excellent opportunity to gain experience in the newest media of patient care. You will be trained at full salary to serve in St. Paul Hospital's second Intensive Care Unit. Openings for all shifts, excellent employee benefits. Inquire: Personnel Department, St. Paul Hospital, Dallas, Texas.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1. Oregon.

ALBERTA

Registered Nurses (2 Immediately) for 15-bed hospital. State salary. Phone or write: Smoky Lake Municipal Hospital #73, Smoky Lake, Alberta.

Registered General Duty Nurses (4) for 32-bed hospital with program of building an addition this spring. Salary $275 - $305; 21-days vacation with pay after 1 year service plus 11 statutory holidays, 1½ days sick leave accumulative. $30 per mo. deduction for room, board & laundry. $10 extra for 11-7 shift. For further information, apply to: Mrs. Pauline Landry, Matron, Municipal Hospital, Fairview, Alberta.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital, centrally located between two very good summer resorts etc. Salary schedule according to suggested A.A.R.N. namely $275 - $300 & adjusted according to experience since graduation. Living in accommodation availble at $30 per mo. & Blue Cross on a 50-50 basis. Apply: Mrs. J/. Bergquist R.N., Matron, Municipal Hospital #43, Bentley, Alberta.

BRITISH COLUMBIA

Registered Nurses for new 250-bed accredited hospital, General Duty all departments. Salary $270, $285 - $342. 1-mo. vacation plus 10 statutory holidays after 1-year. 50% medical coverage. Implementation of superannuation expected this year. 6-mi. from the centre of Vancouver city. Write or wire: Director of Nursing, General Hospital, Burnaby, British Columbia.

Registered Nurses for 29-bed hospital, 35-mi. south of Winnipeg. 42-hr. wk. Starting salary $315; $5.00 increase 6-mo. the first year, $10 yearly thereafter to a maximum of $355. Annual vacation with pay plus statutory holidays. Residence accommodation available. Matron, DeSalaberry Hospital, St. Pierre, Manitoba.

Matron (Immediately) also R.N.'s., for 18-bed hospital. Matron's salary basic $385-$425. R.N.'s $295-$335. Attractive living quarters; excellent personnel policies Apply: Matron, Vita Memorial Hospital, Vita, Manitoba.

Supervisor (Floor) & Assistant Superintendent for small modern General Hospital situated on the beautiful south shore of Nova Scotia. Starting salary $280 gross, $40 deduction for board. Pension plan pending. Course in Supervision preferred. Must have had Supervisory experience. **Also O. R. Nurse** required. Starting salary $250 Apply Superintendent, Fisherman's Memorial Hospital, Lunenburg, Nova Scotia.

Public Health Nurse (qualified with Public Health Certificate) for Haldimand County School Health Service. Salary $3,500 - $3,800 depending on experience 5-day wk., excellent working conditions, starting September 1, 1960. Car allowance $700. Apply stating qualifications & experience to : William T Oster Chairman, Administration Committee, R. R. #1, Cayuga, Ontario by June 10th

ALBERTA ASSOCIATION
OF
REGISTERED NURSES

invites applications for
the positions of
EXECUTIVE SECRETARY, REGISTRAR

Advanced preparation essential

For further information, apply to:

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ALBERTA ASSOCIATION OF
REGISTERED NURSES
10256-112 STREET,
EDMONTON, ALBERTA.

Positions now open.

REGISTERED NURSES

Small hospital in company operated town has vacancies for General Duty Nurses.

Ontario registration required.

Accommodation available in nurses' residence, community organized recreation, welfare benefits.

Salary range $306 - $397 monthly.

Apply to: Matron

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HOSPITAL,
SMOOTH ROCK FALLS,
ONTARIO

NEW MOUNT SINAI HOSPITAL

Toronto

Modern 400-bed Hospital

requires

REGISTERED NURSES

and

Certified Nursing Assistants

40-hour week - Pension plan

Good Salaries and Personnel Policies

Residence Facilities Available

Apply

DIRECTOR OF NURSING
NEW MOUNT SINAI HOSPITAL
550 UNIVERSITY AVENUE
TORONTO

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal

General Duty Nurses (2) for 30-bed hospital situated 130-mi. north of Calgary, Alberta. Situated near 2 summer resorts in Central Alberta's scenic Park Country, the town has daily bus & train service to Edmonton, Calgary & other larger centres. Gross starting salary $270 with a $5.00 increase every 6-mo. for 3-years. Please address all applications to: The Matron, Municipal Hospital, Rimbey, Alberta.

BRITISH COLUMBIA

Director of Nursing (Immediately) must be Anglican. For Anglican hospital with 31-beds & 11-bassinets. Salary commensurate with experience & qualifications, B.C. registration or intentions to obtain it, necessary. Comfortable private apartment in hospital provided. All amenities of country town situated at interior end of famous Fraser River Canyon. Hospital pleasantly located at confluence of Thompson & Fraser Rivers with Canada's best climate. Excellent transportation by road or rail. 4-hrs. from Vancouver, B.C. Please apply, stating salary expected, & giving full particulars of training & experience, to: Administrator, St. Bartholomew's Hospital, Lytton, British Columbia.

Operating Room Nurse for active 32-bed hospital. Personnel policies in accordance with R.N.A.B.C. Apply to: Director of Nursing, Castlegar & District Hospital, Castlegar, B.C.

MANITOBA

Science & Clinical Instructor for School of Nursing, 150-bed hospital, with complement of 60 students, one (1) class yearly. Science Instructor to assist with Clinical instruction on completion of pre-clinical term. Apply: Director of Nursing, General Hospital, Brandon, Manitoba.

Registered Nurses (Immediately) for 21-bed hospital, starting salary $295 per mo. with semi-annual increments, living quarters in hospital, for further particulars, Apply: Matron, District Hospital, Grandview, Manitoba.

ONTARIO

DIRECTOR OF NURSING for modern, approved 100-bed hospital at present considering expansion. Experience either as director or assistant preferred & postgraduate training in administration an advantage. No school of nursing. Salary open. Excellent personnel policies include 40-hr. wk., pension plan, sick leave accumulative to 30 days, 4-wk. vacation after 1-year service, 8 statutory holidays. Apply giving full details of training & experience, salary expected, etc., to: Administrator, Civic Hospital, North Bay, Ontario.

Science Instructor; Clinical Teachers for pediatric & medical-surgical departments; **General Duty Nurses** for surgical nursing. Apply: Director of Nursing, Hotel Dieu Hospital, Kingston, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Public Health Nurses (Qualified) for generalized program, urban & rural. Salary $3,500-$4,250; annual increment $150, pension plan, P.S.I., 4-wk. vacation. Apply: Archie F. Bull, M.D., D.P.H., Medical Officer of Health. Halton County Health Unit, Milton, Ontario.

Public Health Nurses (Qualified) generalized program. Minimum salary $3,417; annual increment $150, liberal transportation allowance & other benefits. Apply to: A. E. Thoms M.D., Director, Leeds & Greenville Health Unit, Brockville, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurse for generalized service in urban area. Personnel policies on request. Apply: Dr. J. E. Gimby, MOH. 235 Wellington Street West, Sault Ste. Marie, Ontario.

SASKATCHEWAN

Registered Nurse (1) for 8-bed hospital in Southern Saskatchewan. Starting salary $280-$320 according to experience, less $30 maintenance; 40-hr. work wk., 3-wk. vacation plus statutory holidays. Apply to: Miss L. M. Peltier, Matron, Union Hospital, Hodgeville, Saskatchewan.

U.S.A.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per month:- Day duty $404 - $423; P.M. & Night Duty $414 - $434; 40-hr. wk., excellent personnel policies. Registration or permit to work in California required. Address applications to: The Chief Nurse, Southern Pacific Hospital, San Francisco 17, California.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $370 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

ONTARIO

Director of Nursing for 105-bed hospital. No school of nursing but C.N.A. course being considered. Degree in nursing administration an advantage. Salary open, personnel policies include 40-hr. wk., pension plan, sick leave. Mark envelope "Director of Nursing", Apply: St. Andrews Hospital, Midland, Ontario.

NURSES
REQUIRED BY
SASKATCHEWAN DEPARTMENT
OF
PUBLIC HEALTH

1. Nurses with Midwifery Certificate for outpost hospitals.
   Salary: $337 - $410 per month.
   Living accommodation provided. File No. c/c 6465
2. Qualified Public Health Nurses for generalized program in health regions.
   Salary: $312 - $379 per month. File No. c/c 6468
3. Registered Nurses for public health work.
   Salary: $288 - $350 per month. File No. c/c 6468

Nurses may apply for bursaries to obtain public health nursing certificates following field work.

BENEFITS: Three weeks holiday, three weeks accumulative sick leave allowance annually with pay, excellent pension and group life insurance plans and other benefits.

APPLICATIONS: Forms and further information available at Public Service Commission, Legislative Building, Regina.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

DIRECTOR OF NURSING,
OAKVILLE-TRAFALGAR MEMORIAL HOSPITAL, OAKVILLE, ONTARIO

INDUSTRIAL NURSE

The Bell Telephone Company has a vacancy for a full time Registered Nurse. The position would require travelling within the Kingston, Belleville, Brockville and Cornwall district. Nurses with postgraduate training in Public or Mental Health interested in this vacancy should write giving complete details of experience and, if convenient their telephone number.

Write:

MEDICAL DEPARTMENT
ROOM 930, 1050 BEAVER HALL HILL,
MONTREAL, P.Q.

GENERAL DUTY NURSES

for 82-bed fully accredited General Hospital. Salary $275 - $315, 40-hour week, no split shifts. Living accommodation in modern nurses' residence and uniforms laundered for $8.00 - $12.00 per month.

Will refund cost of railway fare to Canora, after 6-mo. service.

Apply to:
Superintendent of Nursing,
CANORA UNION HOSPITAL,
CANORA, SASKATCHEWAN.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

JEWISH GENERAL HOSPITAL
MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for General Duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Residence accommodation available.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

SOUTH PEEL HOSPITAL
COOKSVILLE, ONTARIO
(12 miles west of Toronto)

120-bed General Hospital, Opened May, 1958.

I. Evening Supervisor

II. Head Nurse with experience for Nursery (34-bassinettes)

Generous benefits, 40-hour work week.

For further particulars, apply:

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COOKSVILLE, ONTARIO.

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80) bi-weekly until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
In combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four week's notice and the *old* address as well as the new are necessary.
Not responsible for Journals lost in mail due to errors in address.
Authorized as Second-Class Mail, Post Office Department, Ottawa.
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Between Ourselves

June — the month of brides, roses and, this year, our national convention. June may be a very warm month in some parts of our country but we would remind all of you who are journeying to Halifax that June there is usually about the equivalent, temperature-wise, of early May in some other areas. The polar ice is still drifting southward so, though it is away out at sea, the thermometer will reflect its presence. Be sure to bring some comfortably warm attire with you, even if it is 90° when you leave home.

* * *

For many years, nursing organizations at all levels have assigned one of their members as "publicity chairman." Her function, usually approached with timidity born of ignorance and inexperience, was to prepare reports that she hoped the local newspaper would publish without too much abbreviation.

Today, "public relations" is a term that is increasingly familiar throughout the business world. Though the objectives of such a program are somewhat less well known throughout our profession, we have a very active national committee on public relations with its counterpart in each provincial association. Under the chairmanship of Miss Ethel M. Gordon, the national committee has developed a vigorous program which, as guest editor, she describes.

* * *

Interest, enthusiasm and a rewarding vote of approval was accorded the fine presentation of the proposal to seek legislation for a new statutory body — a College of Nurses — in Ontario. Helen G. McArthur, who chaired the Working Party, discusses what is being planned.

* * *

Two articles in this issue are of special interest at this season of the year. June 21 is the first day of summer and to young and old alike summer is the time when they want to "soak up all the sunshine" they can get. People will drive for miles, if necessary, to find a beach where they can sun themselves, perhaps acquire a painful burn or the start of a good tan.

Before you do any sun bathing this summer, read Dr. John M. Knox's article on the effects of sunlight on the skin — then buy one of the available sun-screens. Perhaps your tan will not be so dark but in the long run, you will be kinder to your skin.

* * *

Another result of warm summer days is the greatly increased number of people who go into or on the water. Alas, too many of them do not know even the rudiments of either swimming or boating! The saving of life is so intrinsically a part of a nurse's work that any technique or equipment that can give her new skills is valuable. The Doctors Brook have described the piece of equipment that they designed for Direct Artificial Respiration.

* * *

A few months ago, a reader's letter was published in "Random Comments" in which information was requested regarding retinal detachment. Another reader who had had post-graduate training and experience in eye therapy has sent us an excellent article on that topic. We hope to publish it in our September 1960 issue.

This form of mutual assistance is exceedingly appreciated by your editorial staff.

* * *

What is your personal reading pattern when you open your copy of *The Canadian Nurse?* Many nurses have told us that they skim through first, reading the filler items, noting the personalities whose articles are there, and perhaps concentrating on a short article or two. Later, they go through the issue more methodically.

Immediately following "Nursing Across the Nation" are two items we do not want you to skip over — the tentative program for the convention and the Ticket of Nominations for 1960-62. Be sure to check the latter for the names of the new president and first vice-president, both of whom have been elected by acclamation.

* * *

Finally, we suggest that you take a close look at the Table of Contents page. We are pleased and proud to draw your attention to the fact that Miss Jean E. MacGregor's appointment as an *associate editor* is effective as from the first of the month. Miss MacGregor has been on the *Journal* staff since 1955.

* * *

As president of the hostess association, Miss Margaret M. Matheson sends you warm greetings and an assurance of a hearthy welcome to Halifax, in her brief message.

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Indications—Conditions where glycerophosphate, strychnine, arsenic and cinchona may be indicated.

Description—A tonic solution containing: sodium glycerophosphate, a strychnine salt, fluid extract of cinchona, an arsenious salt, old brandy and glycerin.

Administration—1 to 2 teaspoonfuls 3 times a day.

Manufacturer—Nadeau Laboratory Ltd., 100 St. Paul St. W., Montreal 1.

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Description—Ergot extractive, standardized to contain total alkaloids 1 mg., homatropine methylbromide 1.5 mg., phenobarbital 15 mg., caffeine 100 mg.

Administration—2 tablets at onset of pain to be followed by 1 tablet every 30 minutes (maximum 6 tablets in all) until pain is relieved.

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Indications—For symptomatic relief of colds, urticaria, allergic rhinitis, hay fever, and poisoning from ivy and oak; for treatment of other allergic conditions.

Description—Each tablet contains: pyrilamine maleate 50 mg., dl-methamphetamine HCl 5 mg.

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Description—Each tablet contains: sycotrol (1-piperdine ethariol benzilate HCl) 2 mg., scopolamine methylnitrate 1 mg., magnesium hydroxide 200 mg., aluminum hydroxide 200 mg.

Administration—One 4 times daily or as determined by condition and response of patient.

Manufacturer—Reed and Carnrick, Toronto 16.

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*Obtained from extractives of suitable microbial organisms and determined microbiologically against vitamin B_{12} standard.

Administration—Dosages for 'tweenagers: Prophylaxis: 1 gelseal daily; treatment: 2 or more gelseals daily.

Manufacturer—Eli Lilly and Company, (Canada) Ltd., P.O. Box 4037, Toronto 1.

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Manufacturer—Pitman-Moore of Canada, P.O. Box 44, Don Mills, Ont.

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Manufacturer—Anglo-French Drug Co. Ltd., 209 St. Catherine St. E., Montreal 18.

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Manufacturer—Abbott Laboratories, Montreal 9.

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Administration—Apply to the affected area 3 to 4 times daily. Cover with sterile dressing if indicated.
Manufacturer—Hoffman-LaRoche Ltd., Montreal 9.

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Random Comments

Dear Editor:

Often I have meant to write and congratulate the *Journal* staff on the rapidly accelerating growth in the professional quality of *The Canadian Nurse*. My sincere apologies for not having acted upon these intentions sooner. There may be some consolation in the fact that there are probably thousands of nurses as appreciative yet as tardy as I.

I was particularly interested to read the articles by Mrs. D. S. Starr and Miss C. Blacklock in the February 1960 issue. Mrs. Starr's references to "dependency needs," and the fact that "we urge upon the student nurse consideration of the emotional needs of the patient" should make us older nurses pause and think.

J. P., England

Dear Editor:

I would like to see an article on Multiple Sclerosis in the *Journal*.

In July, 1959 I was told that I had M.S. Since then I have not been able to work because I am too unsteady on my feet. Lately I have heard that there are many Canadians who have this disease.

I am sure that such an article would be very timely. Thank you.

M. F., Ontario

Dear Editor:

Just recently I heard an announcement over the radio concerning leukemia to the effect that in Eastern Canada treatment with "Royal Jelly" has been somewhat successful.

I am very anxious to know more about this treatment as my brother who is 20 years old has leukemia — acute form.

Perhaps you would have information or would have an address where I could write for information.

D. A. B., Saskatchewan

¶*For any who may have heard or read about this method of treatment and who wish for reliable information, it is suggested that The Canadian Medical Association Journal, 150 St. George Street, Toronto, should be contacted.* Ed.

Dear Editor:

As a male graduate of a Canadian school of nursing I think that *The Canadian Nurse* plays one of the most important roles in the nursing profession. It is the introducer, consultant and messenger of ideas for better

knowledge and shares experiences which benefit student and graduate.

Every day new drugs, therapy and procedures come to our attention — some of them unknown in many parts of the world. Thanks to *The Canadian Nurse,* which is alert at all times and ready to carry the "news" of developments, we are able to contribute to health in our country.

The *Journal* has introduced me to others and vice versa; it has helped me to overcome obstacles in my profession; helped me develop better behavior socially and professionally. In its pages you find the most constructive ideas of brilliant doctors and advice from intelligent and conscientious nurses.

I wish that my country, Panama, may some day have a Journal, too, because if we take advice from an experienced country such as Canada we will become more advanced in the future.

I am thankful that I received my training in this lovely country, Canada. It has taught me how to help my own people directly and indirectly as well as how to nurse without segregation as to race, creed or color.

F. G., California

Dear Editor:

I find the March, 1960, issue of *The Canadian Nurse* as interesting as any that has been published for some time.

It occurs to me that a staff member would like to see the name of a school of nursing mentioned when any young graduate submits an article for publication. In this day and age the task of recruitment is great and anything which might help should be mentioned.

Miss Noreen Philpott is a recent graduate of McMaster University School of Nursing just as Miss Nelson is a graduate of the Saint John General Hospital. They both wrote in the March issue.

Florence I. Greenaway,
Associate Director,
School of Nursing,
McMaster University,
Hamilton, Ontario.

¶*Our pattern is to indicate the present occupation of authors rather than the school from which they graduated.* Ed.

All ambitions are lawful except those which climb upward on the miseries or credulities of mankind. — JOSEPH CONRAD

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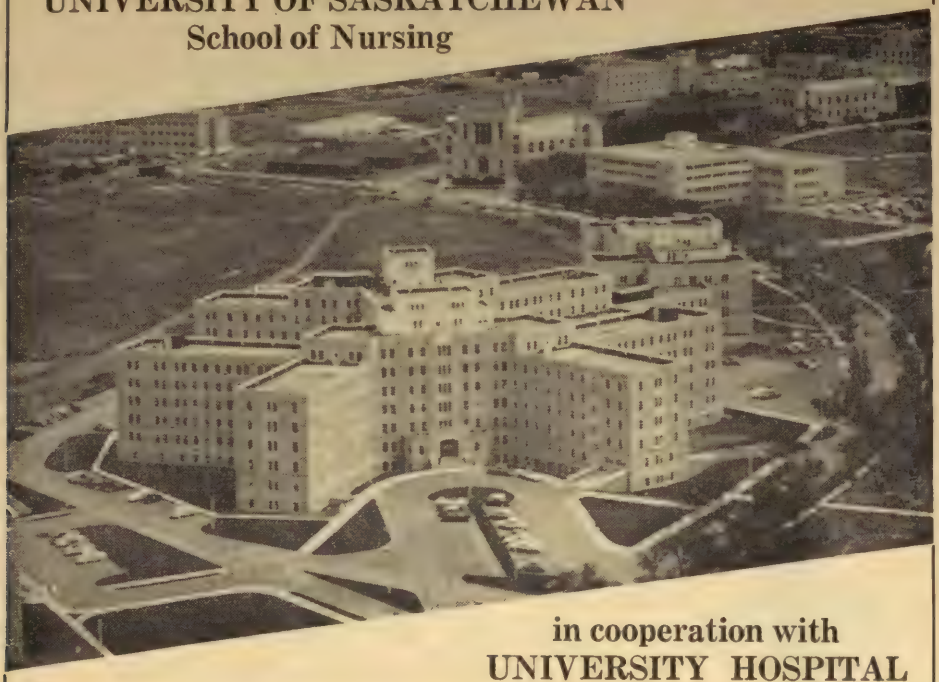
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 6

MONTREAL, JUNE 1960

CIAD MILE FAILTE*

As President of the Registered Nurses' Association of Nova Scotia, I am pleased to convey greetings to my fellow nurses throughout the Dominion.

The nurses of Nova Scotia are eagerly looking forward to your visit. Many years have passed since the biennial meeting was last held in Halifax. A goodly number of changes have taken place in our province since then. We hope that many of you will be returning and will re-visit the areas that you found interesting and also have an opportunity to see our latest developments. We hope that those of you who are coming for the first time will visit many of the beauty spots of Nova Scotia, of which we are so justly proud.

We especially welcome the leaders of our profession who will be guiding our activities during the business sessions. We appreciate that some nurses must remain at home so that care of patients will not be impaired.

We are endeavoring to make your stay in Nova Scotia as enjoyable as possible and hope that many of you may find it possible to remain for a longer time to enjoy our "down East" hospitality.

From one and all, we send you "CIAD MILE FAILTE."

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*The common Gaelic salutation — "One hundred thousand welcomes."

GREAT WAS THE COMPANY

TWO YEARS AGO, the golden anniversary meeting of the Canadian Nurses' Association was held in Ottawa where the CNA had been founded fifty years before. This month, Canadian nurses will meet in the historic city of Halifax for the first general meeting of the second half century of this great Association.

Our second half century! More than fifty thousand strong! Our growth in numbers and responsibility has coincided with the growth in size and complexity of our society and its methods of communication. Hence it has been recognized for some years that a program of public relations is a necessity in our organization. The work of our National Committee on Public Relations is undergirded by two very important factors. First there are the many contacts, national and international, of Miss Stiver and her associates at our National Office; and the voice of *The Canadian Nurse* with its phenomenal circulation jump from 6,000 to 60,000 in 15 years. Second, but equally important is the individual nurse herself, in her contact with the public at all times.



(Newton)

ETHEL GORDON

The Public Relations Committee, consisting of an appointed chairman, and small sub-committee, and the ten provincial public relations chairmen, brings fresh ideas from the membership with each biennium. During its term of office your present Public Relations Committee has been concerned with such matters as the following:

Publicizing the CNA Retirement Plan which came into effect in 1958;

various methods of reaching the general public concerning the place of nursing in our national life. (In this connection the Committee has contributed suggestions for a "Speakers' Manual on Nursing," a publication which is to be prepared in our National Office.);

student nurse recruitment. The committee has prepared and submitted to the CNA Executive the script for two recruitment pamphlets — one for elementary school children, and one for teenagers, parents and teachers;

the preparation of a draft CNA "Platform" (or Guide to Association Activities), for the consideration of the general meeting in Halifax. This "Platform" states the current aims and objectives of the Association in general terms, and would, if accepted, be subject to change at subsequent general meetings.

Although the concept of a public relations program is relatively new, the fundamentals of publicity and public relations are as old as the human race. The writer of the 68th Psalm must have understood sound publicity when he said, ". . . great was the company of those that published it." Modern nursing was born at a time of human crisis, and out of the conviction of a woman who had a passion and a plan and the love of God in her heart. Florence Nightingale, and those earlier women who brought nursing to our shores have endowed us with the symbols of sacrifice and service which are the true bench-marks of nursing.

Between Florence Nightingale and

the nurse of today there is as much difference as between daily life in the smaller world of 100 years ago and the close-knit swirling world of today. Public relations were important then as now; and the soundness of today's "public relations program" is as dependent on each one of us, as was our fledgling profession itself on the integrity and conviction of that one woman in the Crimea.

This year, 1960, finds the whole world in a state of confusion and crisis. Never were the qualities of our nursing heritage more needed. Yet it has become fashionable to consider "sacrifice" and "service" as outdated and stuffy. Surely this is indicative of our confusion!

The nurse plays a dual role in the community — as a representative of her profession and as a citizen in her own right. For her there has always been the need to choose whether her sense of values will be dictated by moral or materialistic motives. In Canada as in every other country today, whether we like it or not, nurses as citizens are involved in an ideological battle for the minds and hearts of mankind. The choice is more than a personal matter. As William Penn has said, "Men must choose to be governed by God or they condemn themselves to be ruled by tyrants." The effectiveness of our public relations — personal, national and international — will be the direct result of our choice.

ETHEL M. GORDON,
Chairman,
Public Relations Committee,
Canadian Nurses' Association.

The Effects of Sunlight on Skin

JOHN M. KNOX, M.D.

Surprising as it may seem, most of the effects of sunlight on the skin are harmful instead of beneficial! Try a sun-screen.

THE TERM "SUNLIGHT" includes visible light, ultraviolet and infrared light, with ultraviolet rays being shorter than visible wave lengths and infrared being longer. Most of the cutaneous reactions produced by sunlight are caused by ultraviolet, for it is these rays that produce the greatest biologic effect on skin. Public interest in the effects of sunlight has centered around sunburn, suntan, and the production of Vitamin D. Few people, including physicians and nurses, are aware of the role chronic exposure to sunlight plays in aging the skin and in the production of skin cancer. Of considerable interest to physicians, particularly dermatologists, is the fact that some people can become allergic to sunlight and develop eczematous or urticarial rashes on sunlight exposed areas of the skin. Also, there are several systemic diseases, the most significant of which is systemic lupus erythematosus, which are adversely affected by sunlight.

The present trend of our culture is in the direction of more time and money for recreational activity, and people are spending considerably more of this time in activities which, by their nature, include many hours of exposure to sunlight. These activities include swimming, sunbathing, golf, fishing, picnicking, hiking, boating and numerous other pastimes. Skin in exposed areas receives a large amount of ultraviolet irradiation from sunlight.

The amount of exposure a person receives depends upon a variety of variable factors which include occupation, geographical location, hobbies, recreational patterns, clothing habits, and the individual's attitude toward the sun. There are two factors which provide natural protection to the skin — the thickness of the *stratum corneum*

Dr. Knox is Associate Professor, Department of Dermatology, Baylor University College of Medicine, Houston, Texas.

and the amount of pigment in the skin. Following an exposure to sunshine the amount of skin reaction is also dependent upon a number of variables, the most significant of which are the duration and intensity of exposure and the degree of natural protection provided by the epidermis. There are more burn-producing wave lengths present in sunlight at midday than early or late in the day; in tropical than northern countries; and at high altitudes in contrast to sea level. Snow, sand and water increase the intensity of an exposure as a result of reflection; whereas, smoke, clouds, shade and clothing provide protection.

Susceptibility to sunburn can be significantly decreased by a tan. The production of a suntan involves three separate and different processes:

1. A few hours after exposure to sunshine there is oxidation of many melanin pigment granules, and oxidized melanin is darker than reduced melanin.

2. Within a few days following irradiation there is a dispersion of melanin granules which causes the skin to appear darker.

3. There is production of new melanin which is a delayed effect that does not reach its maximum for 19 days following irradiation.

The terms "farmer's skin" and "sailor's skin" have long been used to describe the dry, coarse and leathery skin that often develops in outdoor workers. Such skin is prone to develop premalignant and malignant skin tumors. These changes occur in light exposed areas and are the result of many years of chronic exposure to sunlight. It is a fact that fair-skinned individuals who have been exposed to large amounts of sunshine develop more skin cancers than any other group. Negroes are amazingly resistant to the development of skin cancers. Interesting statistics compiled by MacDonald show that skin cancer is more common in areas of intense sunlight and in light skinned races.

Of considerable importance to women is that sunlight accelerates the visible signs of aging of the skin. If one examines an elderly person's skin there is a striking difference between areas that have been chronically exposed to sunlight and those that have been always protected by clothing. A woman will often manifest conspicuous signs of aging of the face and hands, yet the skin of the chest and abdomen may appear normal and manifest no sign of aging. Elderly Negroes often present a deceptively youthful appearance, and this can be explained on the basis of the fact that their pigment protects them from sunlight accelerated aging. The same mechanism explains why blondes frequently show their age more than brunettes.

The current suntan fad should be condemned. A fair-skinned person who wants to tan should not subject his or her skin to the amount of sunlight necessary to produce tanning, and most people who develop a tan easily are already medium to dark-skinned and do not need a suntan for cosmetic reasons. It is somewhat of a paradox that the young people who are vain enough to want a tan will "pay the price" years later, at a time when they actually need to "look their best."

The above-mentioned facts do not in any way mean that outdoor activities should be decreased or discontinued, even for blondes. The point is that the ill effects of sunshine should be recognized and understood so that harmful exposures can be avoided. Protection can be provided through the proper utilization of clothing and sun-screens.

Rothman has shown that a 15 per cent para-aminobenzoic acid cream can increase the amount of ultraviolet irradiation necessary to produce a slight burn by 50 to 100 times. A sizable number of compounds can be used as sun-screens. Those most frequently employed are para-aminobenzoates, anthranilates, cinnamates, pyrrones, benzimidazoles, carbazoles, naphtholsulfonates, and quinine disulfate. Sun-screens have been commercially available since 1928. The first sun-screen was a combination of benzyl salicylate and benzyl cinnamate. New and different sun-screens are continually being introduced. Experiments in our laboratories have found that a new group of sun-screening agents, the benzophenones, are outstanding. They have an exceptionally wide absorption spectra that includes pigment-producing wave lengths and many of the more common wave lengths that cause photosensitivity. The benzophenones are not as yet commercially available. For-

tunately, window glass prevents sunburn by filtering the erythema-producing wave lengths.

In addition to chemical sun-screens, there are certain agents that act as physical sun-screens. Physical sun-screens are occasionally termed "sun-shades" since they are opaque chemicals that scatter light rather than absorb it. Examples are titanium dioxide, talc, kaolin, zinc oxide, and bentonite. These agents are occasionally used in combination with chemical sun-screens. It might be worthwhile to state that a cream vehicle alone will provide some protection, and petrolatum, especially red petrolatum, can provide considerable protection. Most pharmacies can prepare an excellent sun-screen by incorporating 10 to 15 per cent para-amino-benzoic acid in an appropriate lotion or cream.

Before concluding this presentation, it might be worthwhile to mention a few of the diseases in which sunlight is a factor. Sunlight often precipitates or aggravates lupus erythematosus. Xeroderma pigmentosum is a congenital disease in which children develop so many premalignant and malignant lesions in light exposed areas that they seldom live to adulthood. The skin lesions of pellagra and porphyria occur in light exposed areas. A number of the commonly used drugs can produce photosensitivity. Among the more noteworthy are sulfonamides, tranquilizers of the phenothiazine type (Thorazine, etc), the sulfonylurea oral antidiabetic agents, (Orinase, etc.), and the new antihypertensive diuretic agents (Diuril, etc.). The most common skin manifestations of photosensitivity are called polymorphic light sensitive eruptions. It is interesting that lupus erythematosus, the polymorphic light sensitive eruption, and some of the other photosensitivity eruptions will respond to the antimalarial drugs such as chloroquine (Aralen).

It is quite important that every patient who presents a photosensitivity eruption be thoroughly studied since serious systemic disease and a number of drugs can produce photosensitivity. A careful history, thorough physical examination and appropriate laboratory studies will usually reveal facts that will lead to the establishment of the correct diagnosis.

THE MANITOBA HOSPITAL SURVEY

In an effort to assess the province's probable needs in relation to hospital beds, hospital personnel and educational facilities during the next five years and to estimate the present adequacy of the same, the minister of Health and Public Welfare for Manitoba appointed a Survey Board to study the situation.

The board is under the direction of an expert in research and has a representative from the medical field and from hospital administration. Four other members, two of them skilled in research work, one representing the Manitoba Hospital Services Plan and one from the provincial Department of Health, are providing assistance in the work of the board. Finally there is an advisory committee that includes a representative from nursing.

The final report of the survey which is expected in September, 1960 will provide information concerning the following:

1. The adequacy of the overall supply and distribution of hospital bed accommodation in Manitoba to meet present and future needs under the hospital insurance plan.
2. The hospital bed requirements of rural areas, towns, cities and metropolitan Winnipeg; the relative needs for chronic, convalescent and active treatment hospital facilities, as a part of an integrated and balanced system of hospital facilities.
3. The relationship of long-term hospital facilities to alternative-care facilities.
4. The adequacy of the supply and distribution of hospital personnel.
5. The adequacy of educational facilities for training hospital personnel in sufficient numbers to staff present and future hospital facilities.
6. Any other aspects relating to hospital services that may be referred to the Survey Board by the Minister.

BED-PAN HANDS

JULIUS L. DANTO, M.D., WM. D. STEWART, M.D., F.R.C.P. (C.) *and* STUART MADDIN, M.D.

Can the nurse avoid damaging her hands by excessive washing yet maintain the "surgical cleanliness" that is her creed?

WHILE NURSES get dermatological training and formal lectures in the course of their education, these are directed towards the techniques of nursing dermatologic patients. Little or nothing is said about the personal care of the much overworked and mistreated nurse's skin. With the continued use of soap and water for cleaning and scrubbing, the use of green soap and antiseptics for "prepping" patients, cleaning instruments, handling anesthetics, penicillin, streptomycin and other allergy producing medications, it is only curious that the nurses' hands come through the ordeal as well as they do. Added to the above hazards, the ideal of personal cleanliness is so thoroughly instilled into the nurse while still a student, that she is likely to wash her hands with soap and water more frequently than the average person for the rest of her life.

The most common form of dermatitis in women is hand eczema or housewives' dermatitis, produced by excessive use of detergents and soap. It becomes apparent that a nurse will be very prone to this condition while she is active in nursing. After her career, she is even more susceptible than the average housewife when she is married and raising children, washing dishes and diapers, because of the treatment her hands have had while in nursing.

Do student nurses and the august graduates take into consideration the possibility of developing unmaidenly "housewife's hand eczema" on the hospital ward? Probably not very often. What are the chances of developing hand eczema? Fairly good. Why? Everyone's skin will eventually "break down" if exposed to irritants for a sufficient period of time. For example, if ten people repeatedly dipped their hands in turpentine, eventually all ten would develop eczema. Some may develop this after only a few weeks while others may require years of repeated exposure. Nurses do not dip their hands in turpentine but there are numerous other irritants with which they come in frequent contact — soaps, detergents, cleansers, cold sterilization fluids, etc. Repeated handling of such chemicals may cause the skin to become red, scaly, oozy, itchy, and tender. So this is an allergy! No, this is not an allergy. The difference lies in the fact that such substances are irritating in their action. By the repeated removal of the oil, the neutralization of the natural acid mantle of the skin, and the removal of the protective upper horny layer of the skin, a "primary irritant eczema" is created.

In an allergy these factors need not appear. Repeated handling of a substance such as streptomycin, which in itself is not irritating, may produce an eczema at the site of contact with this chemical. What happened? An immunologic change has taken place in the skin. The skin has changed in the manner in which it reacts to this specific chemical, streptomycin. The next time the skin comes in contact with streptomycin it reacts by producing an eczema — an allergic eczema. The entire skin surface becomes sensitive to streptomycin. Once the allergy has been established the application of streptomycin to the skin at a distant test site will produce an eczema at the test site.

Why is it that nurses who have handled soaps, detergents, etc., for many years do not have hand eczema? Two reasons may account for this: the individual may have a great inherent resistance and not be sufficiently exposed to irritants to develop eczema; or, over a variable period of time, they may have developed a resistance to the irritants — in industry this is referred to as "hardening."

Our authors are dermatologists in Vancouver, B.C.

Are some people liable to develop primary irritant eczema more readily than others? Yes — those who have a personal or family history of asthma, hay fever, or eczema are often more likely to develop eczema. Also, those who may have a dry scaly skin (ichthyosis) are more susceptible to this form of eczema.

Are any soaps or detergents *good* for the skin? No! They are all cleansing agents. Some are more efficient than others, some are more or less irritating than others. Other than cleansing the skin no soaps have inherent beautifying properties and their effect on defatting the skin is consistent with each one of them. Do hand lotions and hand creams help prevent hand eczema? Not very much. They are washed off too readily, act as poor barriers of resistance to irritants, and are of very little help in re-establishing the normal acid mantle of the skin. Do hand preparations containing silicone offer more protection? Silicone preparations have proved disappointing and provide little more protection than do ordinary creams and lotions.

What is the best way of protecting the hands? First and foremost, keep to a minimum the frequency and length of exposure to irritants such as soaps, detergents, etc. Secondly, adequately protect the hands with rubber gloves whenever possible.

Another complication of the nurses' duties is a reflection of the "wet work" she is involved in. With bed baths, cleaning of operating equipment and surgical instruments, the number of times her hands are in water prepares her skin for the chronic mixed infection that characterizes *paronychia.* This is a reddened, tender, puffy, swelling of the base of the nails. It often produces a roughened, ridged nail that may even be lost completely. More than one finger is usually involved, and the condition, once started, is chronic and recurrent. Pus may or may not ooze from beneath the puffy tissue at the base of the nail. If left, the infection can spread to other fingers. Monilia (candida) *albicans,* a fungus, is the basic cause of the infection, although there is usually a bacterial infection associated with the yeast. It is directly related to the amount of "wet work" done and is commonly seen in waitresses, dish washers, housewives and bar tenders.

All attempts at therapy with the latest and most powerful antibiotics, antifungal agents, cortisone derivatives, etc. will fail if they do not observe the basic factor: *keeping the area dry.* Avoidance of water and especially soap for a period until the condition subsides is the single most important aspect of successful therapy.

Occasionally, monilial (candida) infection of the fingers leads to monilial infection in other predisposed sites, carried there by contact with the fingers. These sites are the moist, warm, intertriginous areas between the inframammary folds, the axillae, vulvovaginal and gluteal sites, as well as the finger web between third and fourth fingers. These involved areas are inflamed, tender, edematous, moist, and occasionally itchy. With marked involvement they constitute a severe disability. In obese persons they are very hard to eradicate. In diabetics they produce a real hazard to the health of the patient.

Thus the traditionally gentle and skilled hands of the nurse must be protected, in this gleaming world of detergents and polishes, in order to be ready for the next "fevered Brow" or the next batch of diapers as the case may be.

You must do many things. You must become familiar with poverty. How otherwise could you understand human beings who act out of fear and desperation? And how could you know how the poor and the starving feel? You love all your fellowmen and you must know how to make a distinction between what they do and what they are, because what they do could be only accidental; the only thing that counts is what they are. You give all that you can to all that have need before they ask for it and without waiting to be thanked. What you give to others and what you do for others will always come back to you when you are most in need, and not always from the same people. There are some things that do not sell. Give all, because then if you have nothing, you cannot lose it.

— A Gypsy philosophy

Direct Artificial Respiration

Morris H. Brook, M.D. *and* Joseph Brook, M.D.

Victims of suffocation due to illness or accident, in or out of hospital can be aided by this method of "expired-air" resuscitation that circumvents the objections to direct mouth-to-mouth contact.

The modern, proven, and preferred method of artificial respiration is Direct Artificial Respiration (D.A.R.). Though often referred to as "mouth-to-mouth" artificial respiration, D.A.R. may also be performed by mouth-to-nose, mouth-to-airway, and with mechanical devices for positive pressure pulmonary ventilation.

D.A.R. has been adopted as the method of choice by the National Academy of Sciences (U.S.), the National Research Council (U.S.), and is endorsed by the American Red Cross for group training. It has recently been recommended by the Holger-Nielsen committee of the Danish Red Cross.

Positive ventilation through an open airway can usually be accomplished easily by this method, whereas the various manual methods of artificial respiration, (which we shall call indirect artificial respiration), often fail to ventilate the victim due to some degree of obstruction at the back of the throat caused by the tongue.

Manual methods: *Schafer:* dorsal chest compression, *Sylvester:* anterior chest compression, and *Holger-Nielsen:* dorsal chest compression and arm-lift alternately, can often not be applied because of chest, spine, and arm injuries. The indirect methods, furthermore, cannot be applied "on-the-spot" in many instances because of cramped quarters, trapped victim, etc.

Direct artificial respiration can be used immediately in most situations — for example, with a drowning victim even before he can be brought to shore — and is the most efficacious method in all age groups and in victims of all sizes and weights.

D.A.R. can be performed for several hours if necessary to keep the victim alive, or until help arrives. Indirect artificial respiration applied to an elderly or obese victim by a light or young rescuer is virtually ineffective.

To overcome the oft-expressed antipathy to intimate contact with the victim required by the mouth-to-mouth and mouth-to-nose methods, and to minimize the possibility of cross infection, the Brook Airway has been devised to facilitate D.A.R. (Fig. 1).

In cooperation with Dr. A. B. Dob-



Fig. 1. The Brook Airway
Patented 1959

The Airway
When placed in position over the tongue, it helps overcome obstructions, and directs the air to the lungs.
The soft pliable airway is designed to avoid irritation and gagging.
A bite-block (metal insert) prevents collapse of the airway.
The Mouthguard
Provides an efficient seal against the escape of air directed at the lungs.
The Flexible Neck
Is non-collapsible, allowing the airway to be manipulated to any required position.
The Airway Valve
Fits into the flexible neck extension and accommodates the blow tube.
Air is blown through the one-way valve into the lungs.
The exhaled air of the victim escapes through an exhaust port and does not reach the end of the blow tube used by the operator.
The Blow Tube
Fits into the airway valve and provides a mouthpiece for the rescuer.

The authors are members of the Departments of General Practice in the University, St. Paul's and City Hospitals in Saskatoon, Sask.

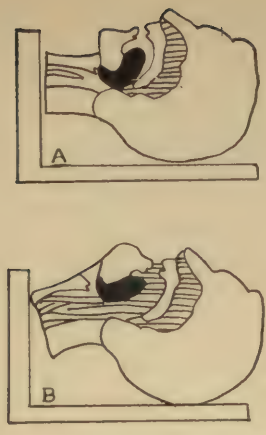


Fig. 2. Air Passage Demonstrator
(A) In the face-up position the lower jaw and tongue fall back, obstructing the air passage. (B) The air passage may be opened by either tilting the head backward or lifting the jaw forward.

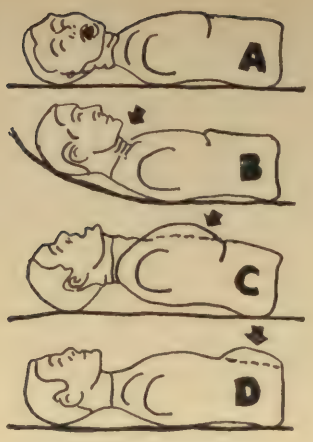


Fig. 3 Brook Manikin
The Brook Manikin is designed to imitate a victim of asphyxia. It contains lifelike anatomical features which enable trainees to learn the fundamental steps of direct artificial respiration by the mouth-to-mouth, mouth-to-nose and mouth-to-airway methods.
The head may be turned to either side for clearing the mouth (A). It moves from the flexed (B) to the fully extended (C) position. The nose contains a nasal passage, which may be closed by pinching the nostrils. The mouth contains a tongue for teaching the insertion of an airway. The air passage is open in the fully extended position and closed in the flexed position. In the neutral position, air may enter both the chest and the stomach. The chest deflates itself; the stomach requires gentle pressure for deflation (D). The manikin may be cleaned inside and out between demonstrations, owing to its special construction.

kin, associate professor of Anesthesia, College of Medicine, University of Saskatchewan, a complete training program has been designed, utilizing the Brook Airway, an air-passage demonstrator which reveals how the tongue may obstruct the air-way and how this may be overcome by tilting the head fully back, (see Fig. 2), a training manikin which simulates a human victim (see Fig. 3), and a training film*, depicting various accident situations and showing how a class may be trained in D.A.R.

Cessation of respiration may result from suffocation due to an accident or an illness. Swimming and boating accidents, highway and street accidents, home accidents, choking, poisoning and electric shocks are examples of accidents causing suffocation. Illness at home, at work, at play and in the hospital may also result in suffocation. Loss of consciousness often results in obstruction of the airway by the tongue falling backwards. This may occur in strokes, heart attacks, epilepsy, eclampsia, allergic phenomena, or even in simple fainting spells. Permanent brain damage or death may result within a very few minutes from lack of air or oxygen.



Fig. 4. D.A.R. — Using the Brook airway
(A) Place victim on back, clear mouth and throat of foreign matter
(B) Insert airway over tongue
(C) Tilt head fully back and support chin
(D) Hold airway in position — pinch nostrils as illustrated
(E) Take deep breath and blow into airway. Repeat every three to four seconds.

Many deaths in hospitals occur suddenly, often unexpectedly, and are discovered by nurses on routine ward rounds. Confronted by this finding, the

*"That They May Live" — 27-minute color and sound, produced by the College of Medicine, University of Saskatchewan and distributed by Pyramid Film Producers Limited, 7166 Melrose Ave., Hollywood 46, California, U.S.A.

nurse may save a life by immediately tilting the head right back, pinching the nostrils, and performing D.A.R. without delay. Do not waste precious moments by leaving the patient to summon help. A signal for assistance should be sent but start D.A.R. at once, and continue until the patient breathes for himself or expert help arrives.

Summary

A nurse is often required to administer emergency resuscitation in the course of her duties in hospital.

The technique of Direct Artificial Respiration for use in emergency on-the-spot resuscitation is described, using the Brook Airway, an instrument designed to overcome the need for direct oral contact in applying D.A.R. The instrument also provides the user with protection against communicable disease.

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Canadian Tuberculosis Association

The 60th annual meeting of the Canadian Tuberculosis Association is being held in Ottawa, June 27-30 at the Chateau Laurier Hotel. The program for the nurses' section will place special emphasis on the role of the public health nurse in the prevention and control of tuberculosis.

Dr. S. A. Holling, director of the Division of Tuberculosis Prevention, Ontario Department of Health will speak on "Newer Trends in Tuberculosis for Public Health Nurses." Dr. W. H. Henderson, director of Community Mental Health Clinics, Division of Mental Health, Ontario Department of Health, and Katherine Fardoe, staff nurse, East York-Leaside health unit will present "Post-sanatorium Care — The Resistive Patient." Dr. Audrey Keeping, Paddington and Kensington Chest Clinic, London, England will discuss case finding and conditions and problems in tubercular control in England.

The executive of the nursing section extends a welcome to all nurses. Those who are returning from the CNA convention are invited to stop over and join in the sessions.

* * *

A child's first visit to the dentist should be at the age of two-and-a-half years. By that time many youngsters have already developed dental caries.

Louisbourg National Historic Park which is slightly over 20 miles from Sydney, is over 328 acres in size. It contains two cairns and four tablets marking historic features plus a fine museum housing hundreds of relics found among the ruins of the old French fortification. Much work has been done in exposing the remains of the old fortress. Old cellars have been cleaned so that the original line of streets can be traced.

WILL BIRD in *Off-Trail in Nova Scotia*

* * *

The first lighthouse on the Cape Breton coast was at **Louisbourg.** It was built in 1731, the first concrete fireproof building in America. Coal was burned in an iron pan set in a tripod, seen six leagues away. An oil lantern was established in 1736, and was shot away during the siege of 1758.

WILL BIRD in *Off-Trail in Nova Scotia*

* * *

Port Morien, beyond Glace Bay about six miles, used to be called "Cow Bay" in the old days. It got this name when a man in Sydney purchased a cow at Louisbourg and took her home by boat. — *Off-Trail in Nova Scotia*

* * *

Doing easily what others find difficult is talent; doing what is impossible for talent is genius. — AMIEL

A College of Nurses for Ontario?

HELEN G. MCARTHUR, M.A.

The most important piece of business discussed at the recent RNAO convention dealt with the proposed "College of Nurses."

OVER 2,000 NURSES at the recent annual meeting of the Registered Nurses' Association of Ontario accepted a challenge to consider a new statutory body under the suggested name, "College of Nurses." This meeting gave new meaning to the question asked by Dr. Allan Gregg some years ago: "What keeps men together in happy and effective association?" His answer: "Three things keep men together: from the past, it is shared experiences; in the present, beliefs generally agreed upon; and for the future, hopes and desires held in common."[1]

The Past: Shared Experiences

A year ago the executive of the Registered Nurses' Association of Ontario was instructed by the membership to secure the legal right to approve the conduct of the schools of nursing in Ontario. This privilege had been long sought by the Association as the major statutory power still retained by the Department of Health since the Association became the registering body for nurses in 1951. When in September, 1959 this request was presented to the Minister of Health, he made an alternative proposal for their study and consideration. This proposal was the establishment of a new statutory body to be called a College. It was visualized that the functions of such a body might include all those requiring statutory powers on behalf of nursing, such as:

a) establishment of minimum standards and curriculum content
b) approval and inspection of schools
c) examinations
d) registration
e) discipline
f) licensing

It was also pointed out that the one area which had not been implemented by statute in some form or other was licensing which, to be effective, must include "all who nurse for hire" along with the power to implement the law and "police" the infractions of the law.

It was further pointed out that extension of the Association's authority would be questioned by many on the basis of vesting such broad statutory powers in a voluntary organization which did not represent all registered nurses and that the Minister of Health firmly believed that membership in a professional organization should be on a voluntary basis. It was also made clear that the advent of hospital insurance had created need for a general review of nursing legislation in which such bodies as the Ontario Hospital Services Commission and the Ontario Hospital Association would have particular interest.

In the next few months, there occurred a sudden flurry of activity within the Executive of the Registered Nurses' Association of Ontario, the Board of Directors and working parties established to do intensive study. This "new" idea was discussed both within the organization and by various interested groups to which the Minister presented the idea for discussion and opinion: the Ontario Hospital Services Commission, the Council of Nursing, advisory to the Minister, on which the Association has representation along with representatives from such bodies as the Ontario Medical Association, the Ontario Hospital Association, schools of nursing and general education. Last January, the Minister of Health called a conference on nursing at which interested professional groups were represented as well as citizens in general. The idea was again aired.

It became clear that, while all the groups considering the concept of a

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Miss McArthur, who is national director of nursing service with The Canadian Red Cross Society, was chairman of the Working Party of the RNAO charged with the development of principles and policies.

College of Nurses had a common purpose, namely ,"what is best for nursing in Ontario?" there appeared to be differences in interpretation of the idea and by some, incomplete understanding of the problems involved. At this point the Association initiated a conference to bring together the groups specifically concerned to think through the implications and to try to reach a point of understanding that would be in the best interests of the public as well as the profession. The nurses were not unmindful that decisions reached might well have implications for nurses and nursing beyond the borders of one province.

A special working party was requested to prepare material for this meeting. Many books and articles were read, day long sessions were spent seeking basic concepts and principles applicable to the problems. Administrative diagrams and procedures were discarded and freedom of thought was sought through a search for principles (Oxford dictionary: *source of action*) which could be applied to any or all professions. Long hours were spent in the Parliamentary Library seeking precedent in Ontario in relation to the legislative patterns in effect for such professions as physicians and surgeons, dentists, pharmacists, lawyers, chartered accountants and professional engineers. These were charted on one great sheet along with nursing legislation in Ontario, in an attempt to seek common patterns and/or principles. The result showed great variation but, in general, confirmed the belief that while the majority of professions had a separate statutory body for the control of minimum standards of education and practices, all such bodies were composed solely of the profession concerned except for the appropriate Cabinet Minister as the elected representative of the people. Particular study of the College of Physicians and Surgeons brought forth both similarities and differences. With this in mind, a set of principles and policies was presented to the groups concerned and agreed upon as a basis for common understanding.

The Board of Directors was then ready to present this "new" concept to the membership of the Registered Nurses' Association of Ontario. The Association could take pride in past accomplishments as a voluntary organization which had willingly carried statutory responsibilities. This had been emphasized again and again by others who were not nurses. The Association had done much soul-searching, information seeking, conferring with interested groups in and outside the government and downright hard mental and emotional work in trying to find the right road to pursue. At the annual meeting, two voices from the past pointed out that the idea wasn't as new as seemed to be suggested. Miss Mary B. Millman, chairman of the Committee on Legislation for the RNAO in 1951, stated that at that time such an idea had been proposed by the nurses but not accepted by the Minister of that day. Miss Florence H. M. Emory, first president of the RNAO, suggested that this opportunity to take a new stride forward had come because the nursing profession in Ontario was now leaving childhood and adolescence behind and was launching out into a period of professional maturity.

The Present: Beliefs Generally Agreed upon

The annual meeting of 1960 has instructed its Board of Directors to seek nursing legislation, based on the concept of a College* of Nurses. The basis would conform to the definitions of a profession long accepted by society, such as that of Dr. Abraham Flexner[2] enunciated in 1915 or that of Mary Parker Follett[3] who spent many years of her life interpreting the meaning of "profession" and who phrased is so succinctly:

> The word "profession" connotes for most people a foundation of science and a motive of service. That is, a profession is said to rest on the basis of a proved body of knowledge and such knowledge is supposed to be used in the service of others rather than one's own purpose.

With this in mind, two fundamental principles eventually emerged and have been accepted by the members of the RNAO:

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*College: defined by the Oxford dictionary as: *an organized society of persons performing certain common functions and possessing special rights and privileges.*

1. A profession has the right to determine its standards of education and practices.

2. The control of minimum standards is through a governing body composed of:

a) representatives elected by every member of the profession residing in Ontario; these to comprise the voting majority.

b) representatives from the organized profession.

c) the appropriate Cabinet Minister.

Several policies have been agreed upon to assure the relationship of the RNAO to its national and international counterparts; to indicate the necessity of liaison with other groups for advisory purposes as well as the necessity to determine the steps which are involved. It is clearly understood that the RNAO will remain a strong professional organization, with virtually the same objectives as at the present time. It is envisaged that there will be an even greater need for its policies in education and practice to be in advance of the possibility of implementation. The provision of official channels for this purpose in the principle of direct representation on the statutory body from the organized profession is not found in the majority of other professions but it has been suggested that in this, the nursing profession has an opportunity to give leadership. Representation from the schools of nursing, both university and hospital, is accepted as essential although the exact formula has not been stated at this point. Nor has the means been clearly formulated whereby the problems inherent in the great numbers of non-professional workers in nursing (estimated at about 30,000 in Ontario) may channel their needs to this statutory body representing over 33,000 registered nurses.

The Future: Hopes and Desires Held in Common

In summarizing the annual meeting to the membership, Miss Alma Reid, a past president of the Association referred to the new development as:

> a new day and a new generation in organized professional nursing. We see this new structure as meeting the needs of the time.

So far, we have made only a beginning. Hundreds of questions have been asked and still are being asked concerning: representation, nomination procedures, financial structure, priorities for implementation, the definition of categories of nurses, the type of secretariat, the physical facilities. The special Working Party, the Board of Directors, individuals and groups have gone through mental gymnastics establishing hypothetical examples of a College of Nurses, with representation by registered nurse population on a district basis geographically related to the RNAO electoral procedure and selected representation from the Association. The Minister of Health becomes the appropriate Cabinet Minister and related bodies have indicated that this is sufficient, having accepted the fact that the aims and the objectives of the nursing profession, the government, and the Ontario Hospital Commission, for example, are one and the same thing: the highest possible standard of nursing service for the people of Ontario.

There will be much hard work ahead in devising the best possible legislation in respect to nursing education and practices. The membership gave authority to the Board of Directors of the Association to continue its work. The officers in turn assured the membership that they would be kept informed of developments as they occur. The past then joined with the future as the four-hour discussion of a College of Nurses for Ontario came to a close at the largest meeting of the Registered Nurses' Association of Ontario on record:

> This development is an instrument through which we might achieve the professional ideals for which we have worked many years.
>
> FLORENCE H. M. EMORY,
> *President, RNAO, 1925*

> To summarize, membership in the organized profession provides opportunities to grow professionally, to become informed, to learn how to become better informed, to participate in nursing affairs and to help chart the path for nursing in the future. For me, much is yet to be learned, but the way is open.
>
> MARGARET MORGAN,
> *President, RNAO, 1960*

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FROM CITADEL HILL

PETER O'BRIEN

Every bit of free time you have while in Halifax can be filled; there are so many interesting and beautiful places to visit.

Jutting like a spearhead into the Atlantic Ocean, the peninsula of Halifax rises irregularly from all sides to the pinnacle of Citadel Hill, centre of the city. This is the site of old Fort George and provides the best view in the city. Just below is the famous old Town Clock built in 1802 at the order of Queen Victoria's father, the Duke of Kent, who, it is said, wanted it to remind the townspeople of the virtue of being on time for appointments.

Looking out from Citadel Hill, we have the city at our feet. We see one of the world's finest natural harbors which is never closed by ice. We see a city that has played a key role in the development of Canada for two centuries.



(Information Bureau, N.S.)

Victoria General Hospital, Halifax

Directly below us on the harbor side is the commercial section of the city with modern buildings reaching skyward. In their shade stand wharves and warehouses bearing centuries-old names.

To the south lies McNab's Island protecting the vast harbor and its installations from Atlantic gales. This is an ideal place for picnics. The waters surrounding the island make enjoyable salt-water sport fishing.

Turning around we see the picturesque North-West Arm, an inlet from the sea, where billowing sails flow between wooded hills, restful bathing spots and aquatic club houses. In this natural beauty site, many Halifonians relax and play. A person may have the impression that he is miles away from busy city life instead of just a few minute's drive.

To the north of the city lies an inner harbor known as Bedford Basin. It was in the Basin that hundreds of ships of the Allied cause nestled safely during the two world wars while awaiting convoys overseas or along the Atlantic Coast.

At the "Narrows" where the harbor joins the Basin, 1,600 persons lost their lives in the northeastern section of the city in 1917 when a French munitions ship and a Belgian relief ship collided and caught fire. The French ship's anchor was blown three miles westward over the city and the Northwest Arm. It can still be seen in its resting place.

South of the Narrows on the Halifax side, the Naval Dockyard is located. This dockyard celebrated its 200th anniversary last summer, and the modern warships that berth there are a far cry from the vessels that docked there when the yard was young

Mr. O'Brien is with the Nova Scotia Information Service, Halifax.

It is easy to enjoy the city of Halifax with its cordial Nova Scotian hospitality, its history and its beauty. Here we have an Old World atmosphere in one of the most historic cities in America. This is testified to by the restored fortress which crowns Citadel Hill and the reminders of long-established naval and military traditions.

Halifax is many things to many people. To the war veteran it is the spot of land that was his last glimpse of Canada as he set off to wars. To the historian it is the birthplace of representative government in Canada; to the businessmen one of the finest ports on the continent; to the visitor it provides a delightful vacation city.

More than 200 years ago Halifax was conceived as the main military and naval base in British North America. It was founded in 1749 by 3,000 civilians under Colonel Edward Cornwallis. First plans were for a sizable town of 50 streets but, for a variety of reasons, this did not come about in a hurry. During the first winter, disease wiped out a substantial portion of the population. Soon afterward, energetic and hardy New Englanders started to move into Halifax.

One of the earliest buildings to be completed was St. Paul's Anglican Church, opened for worship in 1750. It is the oldest Protestant church in Canada. Members of the Canadian Nurses' Association will worship there on June 19. This historic structure possesses the finest collection of funeral hatchments in North America and valuable old silver, as well as memorial tablets and vaults of the noted men of early days in Halifax. Its first organ, since replaced, was taken from a Spanish ship brought into Halifax as a prize of war.

Province House, located on Hollis Street, is one of Nova Scotia's most interesting buildings. This is where the Legislative Assembly and Legislative Council meet. The most beautiful room in the building is the Legislative Library with its lovely Palladian window. At one time the library was a court room and it was here that Joseph Howe made his famous speech defending himself against a charge of libel. Nor should the visitor miss seeing the throne room with its collection of royal portraits and the original table around which Cornwallis and his first council met when the city was founded.



Dalhousie University

Halifax is home to Dalhousie University which opened its doors in 1818. It is said to have been the first university in the world founded without clerical patronage. Its endowment came from customs duties collected in Castine, Maine while that part of the Maine coast was occupied and governed by the British. "Dal" has started many a Canadian on his or her way to prominence in the various professions. Along with Government House, and Province House, the university buildings are built of native stone in early Georgian style. This is in contrast to the materials used in construction of many other buildings and homes in the city. Although built on rock, it has often been easier and less expensive to use wood.

Across the harbor from Halifax is the town of Dartmouth. One can reach it by the Angus L. Macdonald bridge, the second-longest suspension bridge in the British Commonwealth. Completed in 1955, it is only seven feet short of a mile in length. As you drive over, you can look up and down the harbor at the ocean liners, the freighters, the stubby tugs and the naval vessels all snugged into their berths. Once on the other side, you can park near a very modern and recently completed shopping centre and look back at the old city, rich in tradition and history, firmly settled on its rocky base. This is Halifax!

STOP PRESS

CONVENTION GOERS

A CHANGE OF LOCALE HAS BEEN NECESSITATED BY LABOR UNREST AT THE NOVA SCOTIAN HOTEL IN HALIFAX. ARRANGEMENTS HAVE BEEN MADE TO HOLD THE BIENNIAL MEETING SESSIONS IN THE COMFORTABLE AUDITORIUM OF THE **QUEEN ELIZABETH HIGH SCHOOL.** THE GYMNASIUM THERE WILL HOUSE THE BOOTHS OF THE EXHIBITORS.

THE CITY OF HALIFAX IS MAKING ARRANGEMENTS FOR BUSES TO TRANSPORT CONVENTION REGISTRANTS FROM THEIR HOTELS TO THE HIGH SCHOOL.

WE'LL BE SEEING YOU!

In the Good Old Days

(The Canadian Nurse — JUNE, 1920*)*

Legislation for Nursing — There is great rejoicing among the nurses at the passing of the Registration Bill for the Province of Quebec.

The Dutch nurses are hopeful that a Nurses' Registration Act will soon become law in Holland.

There is a strong belief in a uniform international standard of nursing; and by consultation, through national organizations of nurses, as Acts of Parliament are passed in various countries, through the governing bodies set up, it will be possible to define a curriculum of nursing education common to all countries where trained nursing is organized.

* * *

Vivisection — A bill has been introduced into the House of Commons prohibiting the vivisection of dogs. It is strongly opposed by a group of doctors on the ground that the restriction of experiments on dogs would fatally interfere with research now being prosecuted into the cause and cure of certain forms of disease of the heart. There is no suffering of any kind to the animals, the explorations being performed under deep surgical anesthesia from which the dogs do not recover.

Education and Health — It is becoming increasingly recognized that health is necessary to sound intellectual development, and that the rigid regulation of the hygiene of students is indispensable. There is a serious economic and academic loss year after year in schools, colleges and universities, due to lassitude, indisposition, illness and epidemics among the students, all more or less preventable.

* * *

Medical co-education opposed — A petition has been presented to the Dean of the Medical School of the University of Pennsylvania, by the students and professors, demanding the exclusion of women from the classroom. It states that valuable parts of the course have to be omitted less they offend the sensibilities of the women students; and if women desire to study medicine, they should go to Women's Medical College.

A highbrow is a person educated beyond his intelligence. — B. MATTHEWS

* * *

Distance lends enchantment to the view. — T. CAMPBELL

WHITHER WE ARE TENDING

EVELYN MALLORY, M.A.

If we could just know where we are, and whither we are tending, we could better judge what to do and how to do it. — Abraham Lincoln

IT IS NOW 40 YEARS since nursing was first admitted to Canadian universities, and barely 100 years since Miss Nightingale's school for the training of nurses was established at St. Thomas's Hospital in London. It is an appropriate time to pause and reflect on "whither we are tending."

Looking back, one is impressed by the extent to which need and expediency have influenced the development of nursing education in this country. In the early days when services of all kind were lacking, and there were no ready sources from which trained nurses could be drawn, the expedient, and perhaps the only means of meeting the need for nurses, was for each hospital to recruit and train its own nursing staff. Thus, through what Dr. Esther Lucile Brown has so aptly termed "an unfortunate historical accident[1]," the apprenticeship system, with the hospitals responsible for the training of nurses, was established and became firmly entrenched.

Later, the expansion of public health services revealed that hospital training did not adequately prepare the nurse to function in the public field. The university was asked to provide a supplementary course. At that time perhaps this, too, was the only possible solution to the problem. A regrettable result has been the acceptance by nurses, doctors, and the public of the idea that "public health nursing" is something different and apart from nursing in general, an idea that many of us are now striving to change. In any event, beginning in the 1920's, the university responded to the request for one-year courses for graduate nurses as a means of meeting two urgent needs: one for public health nurses, and one for teachers for the rapidly expanding number of training schools. However, graduate nurse students were seemingly considered to be in a different category. The usual standards of admission to the university were not required of them — that came later. For some years the nursing courses remained on the fringes of the university.

Also inaugurated in the 1920's was the "cooperative" program enabling basic nursing students to qualify for a baccalaureate degree. By this arrangement, so familiar to all of us, the student attended the university for two years of study in arts and science, then completed the regular training course provided by the associated hospital. Finally, she returned to the university for another year where she had a choice of the one-year courses planned primarily for the graduates of hospital schools. On completion of these three more or less separate sections of the total program, she received from the university a baccalaureate degree. One



EVELYN MALLORY

Miss Mallory is professor and director of the school of nursing, University of British Columbia, Vancouver. This paper was presented at the Conference of Learned Societies, University of Saskatchewan, June 1959.

wonders whether such an odd arrangement could have been evolved for any other occupational group. Perhaps basic nursing was then considered inappropriate for inclusion in the university. Perhaps it was assumed by all concerned that the hospital school provided an acceptable level of instruction. It may be that the university wisely anticipated, and was not prepared to cope with the practical difficulties entailed in acceptance of responsibility for basic level instruction in nursing. Whatever the rationale, this plan of divided responsibility took root and flourished. It persists to this day, and is very difficult to change despite our long awareness that it is not good educational practice. In 1933, the University of Toronto undertook the teaching of basic nursing but not until 1942 was a degree course offered. The degree conferred was one in *nursing,* whereas previously degrees conferred on nursing students by other universities had not been nursing degrees[2].

The history of the development of nursing education in this country is familiar to all of us. However, brief reference to it seems relevant at a time when we are faced with another need, that for master's level programs. In our desire to meet the need, there is the possibility of too quickly adopting the expedient solution. In earlier years nurses were far from sure of what was needed, wanted, or could be expected from the university. The university, though often willing to be helpful had little understanding of the conditions and needs of nursing education, and considerable doubt as to the wisdom of admitting it to the university. But we have now had 40 years in which to grow and gain in understanding. Developments within our universities indicate their acceptance of responsibility to provide education for the professions. It seems essential, therefore, that we who work in university schools should be clear and in reasonable agreement as to what our university schools should aim to do. It is we who are largely responsible for interpreting to the university the needs of nursing education. As nurses who are in a strategic position to serve as liaison between the university and the organized profession, we have equal responsibility to interpret to the profession what the university can be expected to contribute to nursing education. This latter is important, for the nursing profession is now numerically large, strongly organized, and influential.

However, university schools must be considered and developed in the light of the overall structure of nursing education. While I am fully aware of the autonomy of the provinces in the field of education, of the fact that within each province programs are designed to meet the needs of the people served, and that variety is therefore to be expected, it is my opinion that nursing education is now exhibiting too much variety and that serious consideration should be given to the possibility of reaching some agreement on what our various schools should contribute to nursing education. This need is evident in the plethora of programs for the preparation of nursing personnel. There are:

> the traditional three-year hospital schools; the new two-year "independent" schools (though the independence in some of these is questionable); mental hospital schools giving courses that are two, three, or four years in length; schools for practical nurses; university schools offering basic and/or postbasic courses leading to a baccelaureate degree, and one-year courses for graduate nurses; postbasic clinical courses offered by hospitals; and possibly others.

Taken together these present an uncoordinated structure and make obvious the need for overall planning.

In an article published in 1944 Nettie Fidler, now director of the University of Toronto school of nursing, presented the essentials of a comprehensive plan for nursing education[3]. She suggested that, in respect to education, we should frankly recognize the existence of three groups or categories of nursing personnel, identified as "the assistant group, the clinical group, and the teaching group." She indicated the kind of preparation that should be provided for each. If you have forgotten it, that article would well merit re-reading. Copies of it were widely distributed by the CNA but no official pronouncement made in respect to it. Subsequently the experimental school in Windsor was or-

ganized to demonstrate a more effective method of preparing the clinical nurse than by means of the traditional three-year course[4]. Perhaps because so much effort was devoted to the Demonstration School, the significance of the total plan presented by Miss Fidler received much less attention.

At the Biennial Meeting in 1956, the Committee on Nursing Education recommended that the CNA define the purposes of the various programs in nursing education. It was indicated that this was an essential first step for any effective work on the development of curricula[5]. Though, as an initial step, the nursing schools and the provincial associations prepared statements of their philosophy and aims, probably due to the pressure of other activities, this project has not yet been carried through to completion. It is, I think, a matter of some urgency.

In 1956, following a careful survey in New Brunswick, Dr. Kathleen Russell outlined a comprehensive plan for the development of nursing education in that province[6]. Thus we have been presented with another example of comprehensive planning, in this instance for a particular province. But the CNA, whose responsibility it is to give leadership on the national level, has yet to produce a clear-cut, comprehensive plan to guide the development of nursing education in Canada. In making this statement I am not unaware of the CNA Policies Regarding Nursing Education about which I shall comment later.

In "Education for Nursing Leadership" published in 1958, Eleanor Lambertsen pointed out (as do the CNA policies respecting nursing education) that nursing encompasses a wide range of activities and requires personnel with varying degrees of preparation and skill[7]. Though the terminology used by Miss Lambertsen is different, the overall plan for nursing education that she presented is essentially the same as that outlined by Miss Fidler in 1944. Both Miss Lambertsen and Miss Fidler state definitely that the third group, referred to by Miss Fidler as the "teaching group" and by Miss Lambertsen as the "professional nurse," should be prepared through a university course in basic nursing. In saying that my own thinking is in line with theirs I do not mean to imply that our present university courses are entirely adequate, nor do I suggest that it is impossible for a hospital school to provide the kind of preparation needed by the "teaching group." But it would be extremely difficult, costly, and unrealistic for hospital schools to attempt to do so.

Badly needed at this time is a clear differentiation in the purposes of the hospital school and the university's basic program. These two should not be attempting to reach essentially the same goal. They should not be competing with each other. It is important that this be clearly understood by all concerned. Unless the university offers a program that is distinctly different from that provided by the hospital school there is little justification for its existence.

The university school should provide a broad preparation for general practice on a professional level in any field of nursing. This means that on graduation the nurse would be prepared: to function as a beginning practitioner in public health; to work in mental hospitals as well as in general hospitals; to assume leadership of the nursing team. It implies that, following a reasonable period of staff experience, she would be competent as a head nurse; that she would be capable of the kind of teaching needed at a time when the educational functions of nursing are becoming increasingly important — the teaching of patients and their families, the teaching of nursing students (both the assistant group and the clinical group), the teaching that any public health nurse is called upon to do in the community. It means that she would have an understanding of the fundamentals of organization as these relate to hospitals and health agencies; of the fundamental principles of administration and supervision, and the ability to apply these on a level commensurate with her experience. You will recall that in 1952 Finer recommended the inclusion in the basic curriculum of the elements of administration[8]. Continuing changes in nursing practice make this need increasingly evident.

Nurses with qualifications such as I have indicated are badly needed in nursing service. In my opinion, they

can be prepared more satisfactorily and, in the long view, more economically through a basic course in a university school than through a hospital school followed by appropriate post-basic experience. Preparation of the kind suggested would provide a firm foundation on which to build graduate study, and would greatly facilitate the planning of graduate programs.

What has been said is meant to emphasize the need for clarification of the purposes of university schools, not just by those of us whose responsibility they are, but also by the nursing profession. Without the support of the organized profession what university schools can hope to accomplish is limited.

The CNA and the provincial Registered Nurses' Associations together constitute the organized nursing profession. While the provincial associations must perhaps limit their policies to what is consistent with provincial legislation and has reasonable hope of achievement within their respective provinces, the CNA is bound by no such limitation. It is logical to look to that organization for a comprehensive plan for the development of nursing education, one in which the place of the university (as viewed by the Association) is clearly indicated. As already stated, such a plan has not yet been produced, nor has the CNA ever indicated clearly what it believes to be the function of the university in respect to nursing education.

In "CNA Policies Regarding Nursing Education" we find the statement that "The education of all categories of nursing personnel is the responsibility of the professional group[9]." This is a modification of a statement that appeared in the first edition which was that "Standards of education and practice are definitely the responsibility of the professional group[10]." According to the revision it is not standards of preparation for practice but the education *per se* that is the responsibility of the professional group. This revised statement is both surprising and disturbing, especially since history reveals that in the course of their development other professions have assigned responsibility for education to the university.

Further examination of CNA policies fails to clarify the situation in respect to the university. For example the first major policy reads as follows:

> The preparation of the nurse should be an educational experience and the method by which this can best be achieved is through a school which plans and controls the complete experience of the student[9].

With this we could certainly have no quarrel, but it is followed by another sentence which says:

> The educational interests of the school should be promoted by some appropriate body the majority of whose members should be well qualified in the fields of general education and nursing education[9].

We might well ask: What possible interests could a school have except those of education? What is meant by "some appropriate body?" Does the CNA consider the university an "appropriate body" in respect to basic nursing education? Nowhere in the statement of policies is this made clear. In fact, by their placement, two later sentences might easily be interpreted to imply the reverse. The statement

> In hospital schools of nursing, admission requirements and the curriculum of the professional program should be such as to ensure eligibility for university study[9].

is followed immediately by

> Courses for graduate nurses should be developed and directed by universities[9].

I doubt that the CNA means to convey the idea that the university should not offer basic preparation, but certainly such an interpretation could be made by those persons wishing to do so. The last two paragraphs relating to financial support are also confusingly vague. They read as follows:

> Financial support should be dispensed through educational institutions. Where hospital schools of nursing are deemed to be appropriate educational institutions by the legally constituted body of the province, financial aid should be granted on the basis of the cost of the educational program.
>
> Provision should be made for financial help in developing new educational programs, both outside and within the hospital milieu[8].

How does the CNA define an "educational institution?" On what basis other than the cost of the educational program would financial aid be provided to a school? What is meant by

the "legally constituted body within the province?" Legally constituted for what purpose? And what is meant by "outside the hospital milieu?"

We would like to believe that the CNA does support basic nursing education in the university but these nebulous statements certainly leave room for doubt. I appreciate fully the difficulties faced by the Association in the formulation of policies, having participated in such efforts, and I am certainly not being critical merely for the pleasure of doing so. As a member of the CNA I share, with all other members, responsibility for approved policies and an obligation to support them, but I have also the individual member's privilege and obligation to express my thinking in respect to them. The whole of Canada looks to the CNA for leadership in nursing, but in so far as university schools are concerned the policies are far from clear. It is essential that we who work in university schools know what the professional association expects of our schools. I suggest that the Canadian Conference of University Schools of Nursing should ask the CNA for a clear statement on this point, and that such a statement should be made public. Then at least we would know where we stand and could better plan "what to do and how to do it."

Turning now more specifically to our university programs, let us consider the variety in preparation represented by the baccalaureate degrees in nursing that are offered by Canadian universities.

Some basic curricula are generic, in that they provide a general preparation for all students and include preparation for public health nursing. Others offer an option in the final year, usually a choice of public health nursing or teaching and supervision. This latter practice implies that public health nursing is a specialty, a point on which there are perhaps differing opinions. Is it not time that we reached agreement on a matter that is of such vital importance to our educational programs? Some universities carry responsibility for the entire curriculum. Others assign their students for two or more years to a hospital school program — one which is of necessity planned for students with a different educational background. Yet in our courses in the principles of teaching we stress the importance of considering the background of the learners. In some situations it may not be possible, at the present time, to effect desired changes but we should be able to reach agreement on what we consider good practice and to be forthright in advocating it. Practically all university basic curricula require the completion of first year arts and science (or senior matriculation) for admission and are then, roughly, four years in length. It is my impression that, while the new basic course at the University of New Brunswick will be a four-year program, it will admit students with junior matriculation. As an experimental venture this program will be watched with much interest. I mention it merely to point out the imminent introduction of still another variation.

In our degree courses for the graduates of hospital schools we find at least as great a variation. In some universities students have a choice of specialized courses, *e.g.* public health nursing, nursing education. In others students are required to complete a generic course similar in purpose to that offered the basic level student. There is also the question of the relative value of the basic and postbasic curriculum as it affects the title of the degree conferred. Should it be the same degree in both cases? Even where the nature of the program is the same, *i.e.* both generic or both providing for specialization in the final year, do they in fact represent the same level and quality of preparation? While not quite as pessimistic as Doherty, I am inclined to believe there is some justification for his statement that

> It is hopeless to try to influence the existing attitudes, by and large, of those now constituting the professions — it is too late. They have, most of them, already formed the views and habits which will guide their professional lives, and these cannot be changed by exhortation . . . The time to cultivate a new point of view is during the formative years of professional education, just as this has been the period during which those interests and attitudes that now characterize the different professions have been formed[11].

While there are exceptions, it has been our experience that the majority

of *postbasic* students, even the younger ones, tend to be rigid in their thinking. They find it difficult to consider ideas and methods that differ from what they have learned in their own basic courses.

Are these differences in our baccalaureate programs of no real significance? Certainly they present problems to employers who are finding it increasingly difficult to know what kind of preparation is signified by the degrees from different universities. These differences will also present problems, at least to the applicants if not the universities, in regard to master's programs. In education for other professions the baccalaureate degree is assumed to represent broad preparation for general practice and a sound base on which to build specialization, and preparation for specialization is reserved for the master's level. Should nursing education be different in this respect? Does much of what has heretofore been regarded as special preparation really belong in the basic curriculum? Where and on what basis shall we distinguish between what should be included in the baccalaureate and master's programs?

What do we think about the one-year courses? They were designed to meet specific needs. They are still much in demand, but they do pose problems. Should they and can they be articulated with the baccalaureate curriculum? When nurses who have completed a one-year course wish to qualify for a degree, as many of them do, how much credit, if any, should be granted for their previous courses? Should these courses be completely ignored? If not, how can we equate them with the requirements of the degree curriculum?

There is plenty of scope for variety in the methods used to achieve the goal but surely the time has come when we ought to try to reach agreement as to the general nature and level of preparation that a baccalaureate degree in nursing should represent. Registration requirements ensure a measure of uniformity in the qualifications of the graduates of hospital schools. The majority of provincial requirements ensure that these nurses shall be eligible to proceed to university. Should those of us who are responsible for university programs consider trying to ensure that the majority of our graduates shall be eligible to proceed to graduate study?

What should the master's program be expected to achieve? Should it be generic in nature, providing for specialization through an elective major? Should it be specialized throughout? On what basis should provision be made for specialization — field of activity (various clinical specialities, public health, etc.) or areas of function (education, supervision, administration)? Assuming that the student will devote her full time to study, what is an appropriate length for the course — one year, 18 months, two years? Should field work be required? While these questions will be answered in specific situations by the universities that develop master's programs they are of concern to all of us and are questions on which we might well share our thinking.

Having considered "where we are" in nursing education with particular reference to university schools and having stressed the need for clarification of "what we ought to do," let us discuss certain aspects of "how to do it."

Several years ago at the University of British Columbia we decided that we should try to straighten out our own thinking by preparing a statement of the philosophy and aims of our school. We undertook this as a staff project and devoted much time and effort to it. In respect to the basic curriculum we said simply that our aim was to prepare the professional nurse. This sounded fine until one of our young instructors asked "But what do you mean by the professional nurse?" At first we thought this a silly question, but when we tried to define the professional nurse in terms that would guide the planning of a curriculum we found it far from easy. Eventually we produced a description of our concept of the professional nurse, only to realize that the new graduate from our basic course could not be expected to measure up to the standards we had set. So then we had to define what we believed our student could reasonably be expected to have achieved on the completion of her course. This effort resulted in the



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following statement, not with the thought that it would be necessarily appropriate to any other situation, but because it represents our thinking regarding what a student should gain from a baccalaureate course.

We believe that a nurse with a Bachelor of Science in Nursing degree from the University of British Columbia should:

1. Have a reasonable understanding of her own society and be able to participate as a citizen and a professional person in the promotion of human welfare;

2. have an appreciation of her professional heritage and of her responsibility as an individual to work through her profession for the advancement of nursing in the interests of society;

3. be able to work effectively with people, both individually and in groups;

4. be able to recognize and deal constructively with nursing problems which she will encounter in the course of her professional activities;

5. understand principles that are fundamental to the practice of nursing and be able to utilize principles in the adaptation of methods and techniques;

6. have sufficient skill in the performance of nursing techniques and procedures to enable her to give good nursing care;

7. understand basic principles of learning and teaching and be able to plan and carry through effective teaching of individuals and groups;

8. understand the elements of administration and be able to implement them at her level of competency;

9. understand the modern concept of supervision, be able to benefit from supervision, and be able to apply basic supervisory skills and techniques on a level commensurate with her competency.

With the preceding statement as a guide, we made possible adjustments in our program which was, at that time, of the kind I have referred to previously as "cooperative." Then we tucked the results of our efforts away in the files. About a year ago when our school became responsible for its entire curriculum, we reviewed our previously constructed statement and decided that it needed only minor changes. But when we settled down to the task of planning the clinical nursing sections of the curriculum, our complacency was completely shattered by the realization that these broad statements were totally inadequate as a basis for organizing learning experiences for students. Each statement had to be carefully analyzed to ascertain what it involved. For example, in reference to the "ability to recognize and deal constructively with nursing problems that she will encounter in the course of her professional activities," we had first to define what we meant by "nursing problems." Then we had to identify the more specific abilities that the student would need in order to be able to deal "constructively" with them. We decided that she would need ability

to observe,
to interview,
to record and report pertinent data,
to identify and state problems,
to analyze problems,
to gather and assess relevant data,
to plan with patients and others for the solution of problems,
to take appropriate action,
to evaluate the results of action taken or withheld and to learn from the experience.

After analyzing in a similar manner all nine of our general statements, we were dismayed to find that the result was still inadequate as a basis for planning learning experiences and that we would have to decide what levels of achievement in respect to each specific ability should be expected of the student at various stages of her program. Out of this latter activity another question arose. How could we know that the student was in fact developing the desired abilities? Our next step was to try to describe appropriate behavior at various stages of the program, and this phase of our task is still in progress. However, it was cheering to discover that, when this particular phase of the task has been completed, we will have not only a guide for the selection of learning experiences, but also the essentials of a guide for the evaluation of the student's progress. Out next step was to take the outline of abilities to be developed and the levels of achievement to be expected at the various stages of the program and, in consultation with the key personnel in the clinical areas where our students are to be placed, to plan the learning


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experiences which the areas could provide.

A few of our staff had had courses in curriculum construction and the majority had gained at least some knowledge of the process from professional reading. But the theory of curriculum construction acquired an entirely new meaning when we proceeded to apply it in our efforts to take a fresh approach to the planning of our new program. Though very time-consuming and often frustrating, it has been an exciting experience to discover that the theory propounded by the experts actually works! Efforts to apply the deceptively simple principles of curriculum construction have forced us to clarify vague and fuzzy ideas. In so far as we can judge at this time, these same principles have been conducive to realistic planning. It has been very helpful to have all members of staff involved. The younger and less experienced members accept nothing on faith but are constantly asking challenging questions, and they persist until they receive satisfactory answers. We know that our first overall plan will have many defects that only experience will reveal, and that it will require extensive revision after the first trial and continuous modifications thereafter. But we are convinced, as never before, that the procedure is sound, and that it provides a very satisfying approach to the task of building a curriculum.

Discussion of the curriculum inevitably brings up the question of practical experience. Authorities on the subject of professional education tell us that a satisfactory program consists of a judicious mixture of general courses (sciences and the humanities), special courses (peculiar to the profession), and practical experience under the guidance of an expert. It is in this area of "experience under the guidance of an expert" that our greatest problems lie.

What degree of skill in the performance of nursing techniques is it reasonable to expect of the new graduate of a degree course in basic nursing? We find there is, at least at times, a tendency to judge her in terms of the performance of more experienced nurses. Should we accept this as a reality and hold our students in the program long enough to ensure a relatively high degree of skill? Or should we try to gain acceptance of the idea that the new graduate, even though she holds a university degree, is a beginning practitioner — one who has a functional knowledge of the fundamental principles on which nursing is based and can be expected to apply them intelligently; one whose skills are those of a beginner in the professional field and who can be expected to continue to grow and become increasingly skilful? The answer to this question will influence the kind and amount of experience to be included in our programs.

The same question arises in connection with courses for the graduates of hospital schools. There has been discussion of the possibility of not requiring field work in some of these courses. Certainly we know that in some of the advanced level courses offered in the United States no field work is included. If the purpose of the professional school is to prepare individuals to practise their profession competently, how can the school vouch for the competence of its graduates if no field work is provided? At UBC we consider field work an essential part of all of our curricula. We will not, at any time, recommend a student for either a degree or a diploma until she has demonstrated an acceptable level of performance. It is also a matter of considerable importance to employing agencies to know whether the degree or diploma presented by the applicant for a position indicates that she has demonstrated ability to function in an acceptable manner, or merely that she has mastered the theoretical knowledge essential for practice. The information has a bearing on the kind of orientation program to be provided for the new employee, as well as her placement within the agency.

The provision of a high quality of field experience for students requires that those persons who act as field guides have a background of education and experience at least equal to that which the student will have attained on the completion of her program; and that they have an understanding of the student's total program and of what the field experience is expected to contribute to it. It is therefore essential



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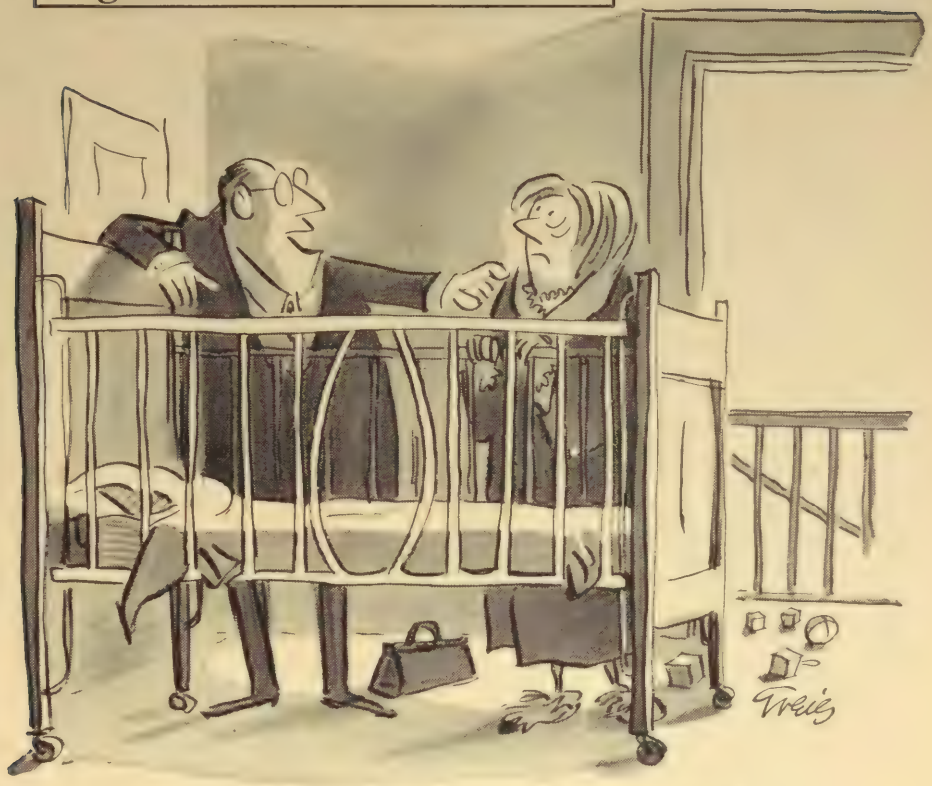
that the university staff work closely with the field agencies; that the agencies be provided with a statement of the objectives of field work and that they be given guidance in planning field experience for students. The university should provide background information about each student, including her special needs and interests. A member of the university staff should be available for consultation if needed during the period of field experience. Also, through periodic group conferences all agencies that accept students should be kept well informed regarding any changes in the total program and should be given opportunity to make suggestions in respect to it.

Direct supervision of field students should be provided by the agency's staff. In our experience this rarely presents any problem in the public health field. On the whole our public health agencies are staffed with qualified public health nurses and the members of the supervisory staff have had advanced preparation. There is a growing problem, however, due to the increasing demand being made on the agencies both by the universities and hospital schools that are seeking public health experience for their students. While experience for the latter group is desirable, it should not be permitted to jeopardize experience for students who are being prepared for practice in the public health field. Perhaps the CCUSN might suggest to both the Canadian Public Health Association and the CNA that they consider recommending the establishment of priorities in respect to public health experience for students. This has already been done by some agencies but a recommendation from these two national organizations might be very helpful.

The problem in respect to the supervision of field students in hospitals is more difficult. In our province at least, there is a shortage of head nurses and supervisors with the background desirable in those responsible for guiding field students. Regardless of how competent she may be in the management of her unit, without an understanding of the total program and of what the field experience is expected to contribute, the value of what the head nurse can provide for the student is limited. The provision of field experience in hospitals requires infinitely more attention from university staff during the period of experience, than is the case in the public health field. This is partly because the field experience for these students is more varied and planned on an individual basis; partly because the students need opportunities to discuss their problems with their instructors; and partly because the instructors want to see their students in action so as to evaluate their ability to apply the principles of teaching, supervision and administration. If and when there are more fully qualified head nurses and supervisors in hospital areas, the problem of providing good field experience for our students will become much less difficult.

You may be interested in a practice that we have followed for the last five years, which seems to us to be very satisfactory. Students in the final year of the degree course are assigned responsibility for our first year students during the period of their initial experience in clinical areas. Under the guidance of their instructor, the final year students devote one class period a week during the spring term to preparation for this part of their field work. First year students are placed on wards for an eight-week period in May and June. This coincides with the timing of fourth year field work. One fourth year student is given responsibility over a four-week period for two or three first year students. In the beginning we wondered if the change halfway through the eight-week period would prove disrupting to the first year students and to the wards. We find that, as a rule, the transition is made easily and quickly. This plan provides excellent field experience for the fourth year students, and it promotes a quick and effective adjustment of the first year students to the clinical areas. In fact, we have been surprised and extremely pleased to discover that this arrangement is better than a previous plan of reserving this particular field experience for the graduate-nurse students taking clinical teaching and supervision who carried the same assignment through the full eight-week period. We should not have been surprised since it is to be expected that final year students in the degree course,

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goes on . . . and on . . . and on



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having had the same program, would be more familiar with the background of the first year students. They have demonstrated greater ability to help the young students to see significant relationships, to apply to nursing situations the knowledge they have gained from their science courses, and to work from basic principles. The initiative, imagination and poise which some of these young fourth year students have shown in their teaching have been a joy to their instructors.

The last problem which I shall mention — one of which we are all keenly conscious — is that of obtaining qualified staff for our university schools. The dearth of suitable instructors certainly adds cogency to the need for master's programs. It is only reasonable that general university policies respecting staff appointments should be applicable to the school of nursing. This usually means that a master's degree is required for appointment within the regular stream of the academic staff. In respect to nursing it is almost impossible to obtain instructors with that qualification, particularly for teaching in the clinical areas. Of the few inquiries that we have received within the last year or so from persons holding a master's degree, practically all were seeking administrative positions. The situation is perhaps particularly difficult for those schools that offer a generic program. In these schools it is desirable that the clinical instructors have a background in both clinical and public health nursing. Otherwise they are seriously handicapped in their efforts to help integrate public health aspects of nursing throughout the entire curriculum.

Mental illness is one of our major public health problems. Our graduates should be prepared to participate in efforts to promote good mental health and to serve in psychiatric hospitals. Yet it is practically impossible to find instructors who are prepared to teach in this area of the curriculum. The lack of instructors aggravates the situation since without them we are unable to prepare interested graduate nurses for work in this field.

Summary

What I have tried to do is to highlight, not the strengths and progress of nursing education, but some of the difficulties and problems facing us. Having been for 34 years a fairly active member of our nursing associations, both provincially and nationally, and having spent the past 17 years in a university program, I have had opportunity to develop some awareness of the situation, limited and perhaps biased though my viewpoint may be. Recently, when browsing through a magazine, I encountered one of those little quotations that editors dearly love to insert in their spare corners. It was to the effect that you cannot both antagonize and influence people. I have no wish to antagonize, and little hope of influencing the course of nursing education, though I believe that a united and strong CCUSN could do so. What has been presented represents my own thinking in respect to certain aspects of nursing education in this country, particularly as they relate to university schools. I suggest that a university school should

First, and of greatest importance, offer a baccalaureate curriculum that will provide broad preparation for general practice on a professional level in any field of nursing and a sound foundation on which to build graduate study.

Second, provide a curriculum that will enable the graduates of hospital schools to attain a comparable level of preparation.

Third, as soon as conditions are favorable, organize a master's program to prepare nurses for senior level positions in nursing education, nursing service and nursing research. My present thinking is that a master's program should provide a general knowledge of all three areas with an elective major in the field of special interest.

Fourth, as long as these are required, continue to offer one-year courses to meet the service needs of hospitals and public health agencies; but recognize these courses as an expediency and stop trying to provide the same content and level of instruction as is given in the final year of the degree course. To do so means that the content and teaching are appropriate to neither group.

Fifth, provide institutes, extension courses, and consultive services to the extent possible without jeopardizing the major program.

I have described certain aspects of

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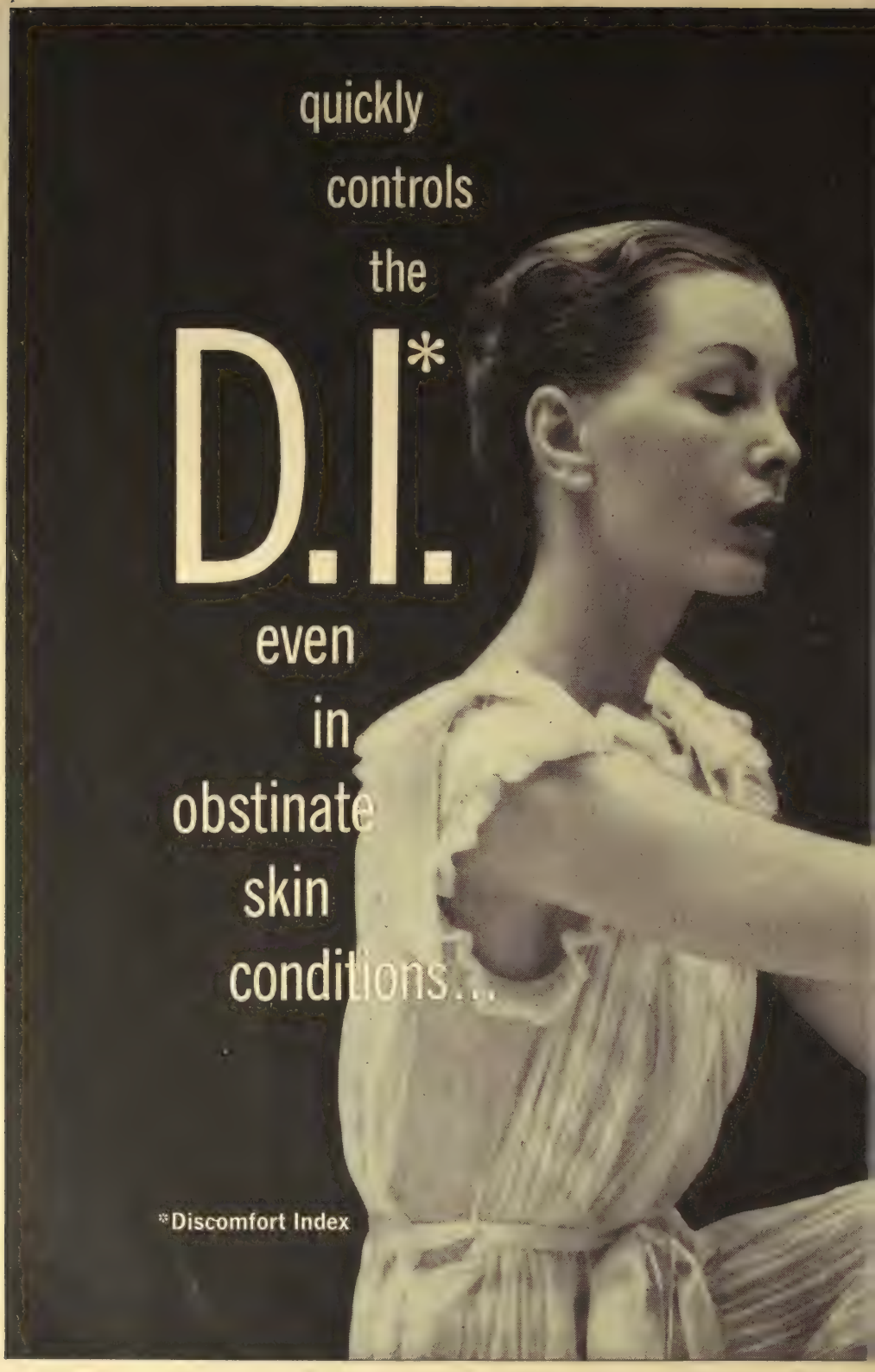
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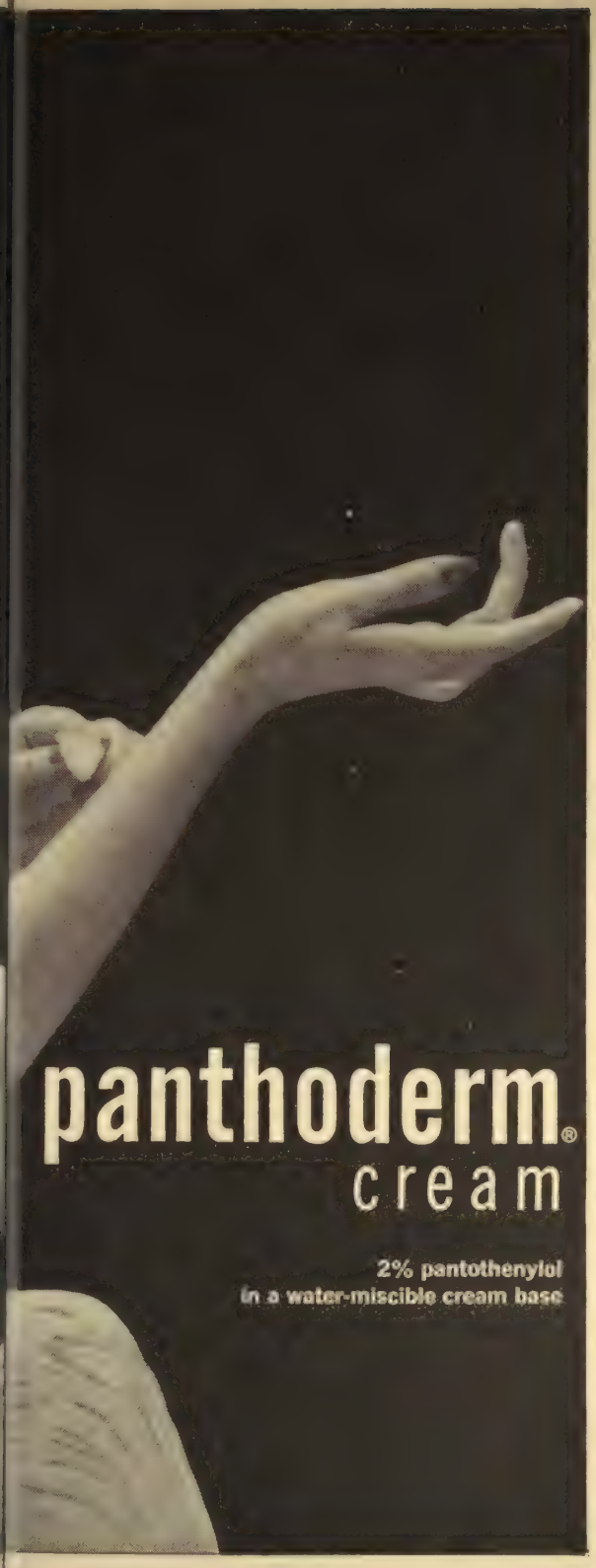


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our efforts at UBC to develop a functional curriculum; presented some problems regarding field experience; and, by implication, have pointed out the relation of our difficulties in obtaining qualified staff to the variation in the nature of baccalaureate programs now being offered across the country. I do not ask that you agree with the ideas expressed, merely that you accept them as the outcome of an effort to view the situation objectively if not dispassionately. People usually feel strongly about the things that are important to them, and nursing education *is* important.

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A study was undertaken to determine the extent to which a nursing interview in an out-patient clinic could increase:

1. the patients' ability to understand and carry through treatments
2. the patients' general satisfaction with clinic visits.

A randomly selected group of new patients was seen following the doctor-patient interaction in order to question, clarify or discuss problems related to the patients' treatment and well-being. A control group went through clinic in the usual manner. The doctor-patient interaction of both groups was observed and recorded. Both groups were interviewed on their return visit before seeing the doctor to determine their understanding of treatment and orders given in the previous visit and their success in carrying through these orders at home.

The data obtained support the hypothesis that in a clinic situation, if a patient is given the opportunity to question, clarify, or discuss problems related to his treatment and well-being, then he will be better able to carry through the medical advice given to him. It was found that there was a close relationship between the patient's understanding of treatment and his ability to follow through medical advice at home. The nurse appeared more effective with lower class patients, and with non-white patients. She clarified more of the treatment orders with these patients and they expressed a high level of resultant satisfaction.

Abstracts from Studies in Nursing — Yale University School of Nursing, New Haven, Connecticut.

* * *

More than 65,000 Canadians died in 1958 of heart disease; more than 250,000 were disabled by heart disease; more than 80 million dollars were lost as direct income of its victims; more than 125 million dollars were the conservative cost of care and treatment.

In 1958 Canadian spent over four times as much on valentines as they did on heart research, 25 times as much on fleeting tributes to victims of heart disease. Over 100 million dollars was spent on industrial research for product or production improvement. Less than one milllion was contributed in the same period to heart research by the whole nation.

Health Newsletter, Saskatchewan Department of Public Health

* * *

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— Dorothy Duncan

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NURSING PROFILES

The news that the Victorian Order of Nurses for Canada had a new director-in-chief was released late in March and we take much pleasure in extending sincere congratulations to **Jean Cecilia Leask** on her appointment.



(Ashley & Crippen)

JEAN LEASK

Although she has been assistant director in the division of nursing in the Toronto Department of Health for the past few years, Miss Leask is not a newcomer to the Order. As a young graduate from the University of Toronto School of Nursing, she joined the Toronto branch in 1936 and remained with it until December 1939 when she transferred to Regina as nurse-in-charge of that branch. A one-year Rockefeller travelling scholarship gave her an opportunity in 1941 to observe various official agency programs both in Canada and the United States. She returned to the Toronto branch as supervisor in January, 1942. In 1952 she did postgraduate study at the University of Chicago, majoring in public health nursing administration, and obtained her Master of Arts. She had previously obtained her Bachelor of Arts degree from the University of Toronto.

The Victorian Order of Nurses is a unique agency, distinctly Canadian, and with a proud record of service to the citizens of this country. Miss Leask is representative of the highly experienced, devoted and capable nurses who, since the foundation of the Order, have directed its activities and won for the VON an unequalled degree of community esteem.

* * *

Early this year arrangements were completed for an extension course in nursing unit administration under the joint sponsorship of the Canadian Nurses' Association and the Canadian Hospital Association and with financial support from the W. K. Kellogg Foundation. The director of the project is **Mary Kathleen Ruane** who, since 1954, has been director of nursing service at University Hospital, Saskatoon.

A graduate of Misericordia General Hospital, Winnipeg, Miss Ruane attended the University of Manitoba where she received her certificate in teaching and supervision. Several years of experience in supervisory positions preceded her appointment as superintendent of nurses at The Children's Hospital, Winnipeg in 1945. In 1954, she relinquished this post to assume her duties in Saskatoon. An active leader in nursing, she has brought distinction to University Hospital and to her profession in the various capacities in which she has served it.



M. KATHLEEN RUANE

Some time ago the Registered Nurses' Association of Ontario sponsored a study of registration examinations. The report resulting from this investigation recommended the appointment of a nurse, experienced in







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the field of nursing education, to develop, interpret and administer objective type, machine-scored registration examinations. It is expected that **Dorothy Rebecca Colquhoun** will join the RNAO staff in this capacity during the summer.

A graduate of The Montreal General Hospital and of the School for Graduate Nurses, McGill University, with a Bachelor of Arts from McGill as well, Miss Colquhoun obtained her Master's degree from Columbia University this year. Until she resigned to continue with postgraduate study, she was director of the school of nursing, Metropolitan General Hospital, Windsor, Ont. She has had considerable experience in the field of nursing education beginning as senior instructor, Royal Jubilee Hospital, Victoria, B.C. Later, after service with the RCAMC during World War II, she went to Port Arthur General Hospital as director of nursing. This was followed by a teaching position at the University of Alberta School of Nursing.

In addition to the active role that she has taken in professional affairs, Miss Colquhoun has an interesting range of leisure-time activities that include bridge, oil painting and record collecting.



(Garland Studio)

SHIRLEY NEWHOOK

Shirley A. Newhook began her new duties as divisional director of nursing services with the Newfoundland division of the Canadian Red Cross Society in April. A graduate of Grace Hospital, St. John's in 1958, Miss Newhook has had postgraduate experience at the Montreal Neurological Institute and was on the staff of the West Coast Sanatorium immediately prior to her present appointment. Keenly interested in the activities of the Red Cross Society, she has also taken an active part in the Girl Guide movement.

The Canadian Red Cross Society takes much pleasure in announcing her appointment and, from her nursing colleagues, sincere good wishes and warm congratulations are extended.

The Sadowski Studio at **Indian Harbor** is the only one of its kind in Eastern Canada. The story of the owners, Mr. and Mrs. Konrad Sadowski, reads like fiction. They first met in Brazil where Konrad Sadowski had been sent by his government to teach physical training to the Polish immigrants and where Kryslyna Sadowski was teaching weaving. Shortly after they were married, World War II broke out and Konrad joined the Polish Air Force. Imprisoned by the Russians, a Polish patriot helped the couple to escape to Hungary and eventually, in a very roundabout way, they reached England. At the end of the war the couple returned to Brazil. There, in 1949, a member of the Canadian Embassy saw a tapestry done by Mrs. Sadowski called "A Dream of Canada" — an expression of the artist's longing for a country that she had never seen. Shortly afterwards the Sadowskis were invited by the Government of Nova Scotia to come to Halifax to assist in teaching weaving and pottery. They established their studios at Indian Harbor.

Mrs. Sadowski uses ancient Polish techniques for weaving, uses handspun wool and dyes it herself. Her husband uses old Babylonian methods in turning out his pottery in which the shaping is done by use of a potter's wheel.

WILL BIRD in *Off-Trail in Nova Scotia*

* * *

Do you know that conversation is one of the greatest pleasures in life? But it wants leisure. — SOMERSET MAUGHAM

* * *

Most of the change we think we see in life is due to truths being in and out of favor. — ROBERT FROST

* * *

The biggest dog has been a pup. — MILLER

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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Convention Highlights

As we write these lines National Office is busily engaged in final preparations for the 30th Biennial Meeting of the Canadian Nurses' Association being held in Halifax, June 20-24, 1960. Our eastern nurses have been very busy planning interesting and varied entertainment. A hearty welcome, an excellent program, new hotel facilities and entertainment to suit all interests awaits you.

Your Executive Committee will remember for many years the occasion of the presentation of the **Report of the Pilot Project on the Evaluation of Schools of Nursing in Canada** by the Director, Miss Helen K. Mussallem at the CNA Executive meeting held in Ottawa, February 1960. All Convention registrants will have the same opportunity to witness the results of this exhaustive study as one full day has been set aside for the discussion of this report. Special luncheons and group discussions are being planned to give opportunity for study of this report.

The CNA joins the world in celebrating **Mental Health Year** by presenting a case conference "The Patient Returns to the Community" followed by a panel discussion, with opportunity for audience participation.

Other topics on the program are the presentation of reports, hospital insurance and its impact on nursing, and nursing legislation with international participation.

Those of you who had the opportunity to be present at the colorful and gracious ceremony of the presentation of Honorary Memberships at the 50th Anniversary Meeting, Ottawa 1958, will be pleased to learn that the CNA plans to conduct a similar tribute in Halifax.

Traveling by train? Entertainment awaits you from the moment you board the train until you say au revoir to both old and new friends as the meeting closes. The CNR special convention train offers an opportunity to get acquainted through planned activities en route to the shores of the Atlantic. We'll hae the pipers out to meet ye! For further information write to your provincial transportation chairman.

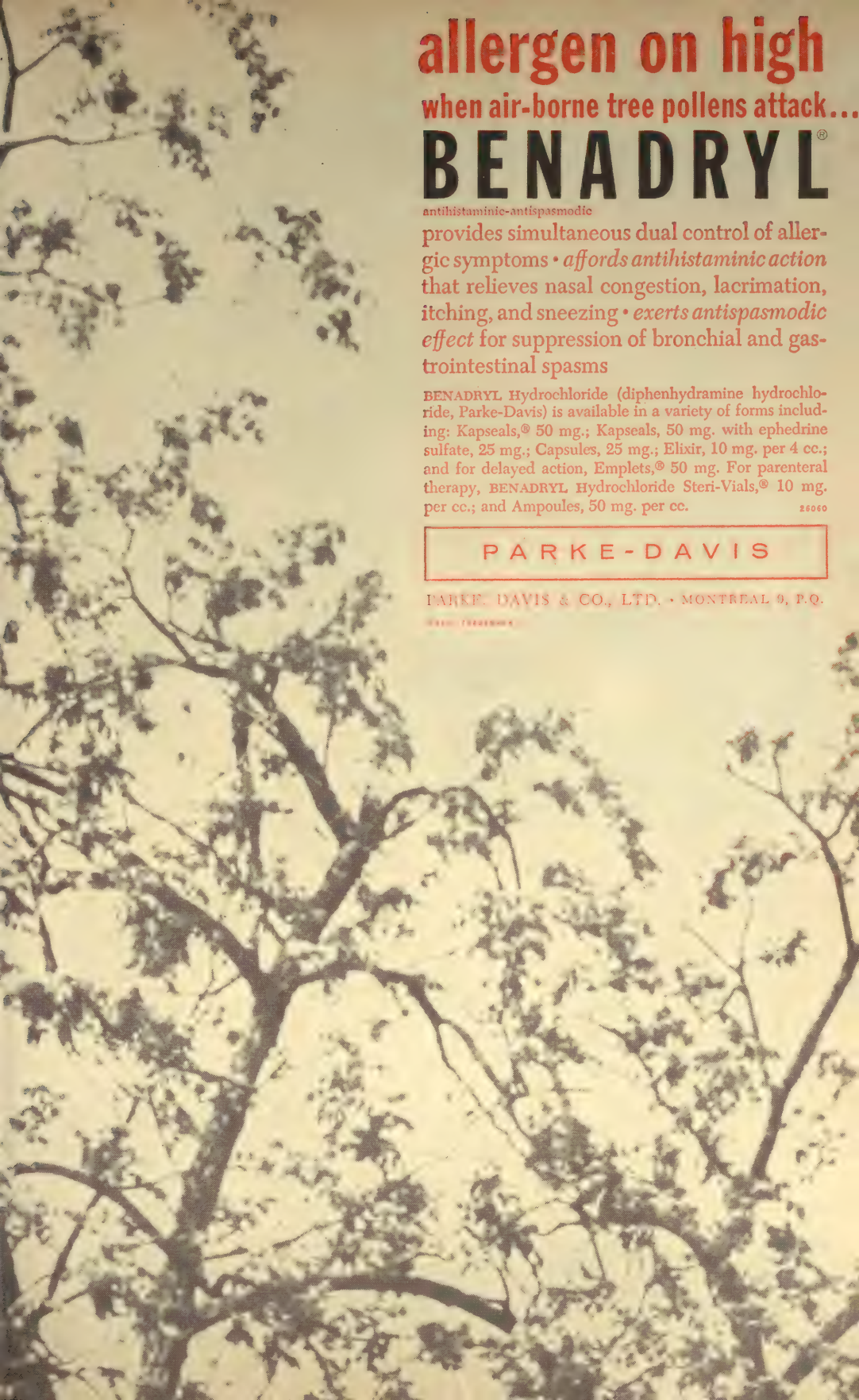
The Government of Nova Scotia cordially invites you to a Garden Party to be held in the Public Gardens, Halifax. Your President extends a warm invitation to the President's reception at which time the Guntar Buchta dancers will entertain you with their ballroom dancing. The Registered Nurses' Association of Nova Scotia has planned a reception to be held following the close of the convention. A harbor cruise followed by a lobster supper has been planned for the mid-week free afternoon. Opportunities are also available for visits to neighhoring spots of scenic interest.

It's not too late to register. July is vacation month for many nurses and the CNA has arranged for special tours, following the convention, to Europe, Bermuda, New York, St. Pierre and Miquelon, Newfoundland and the Maritime Provinces. Pamphlets illustrating these tours are available in National Office.

Why not come to the meeting and then take advantage of the many vacation opportunities that are yours for the asking? CNA National Office welcomes receipt of your application for registration and will arrange suitable accommodation.

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during the past biennium we realize that these advancements could not have been made without the wholehearted support of our members across Canada. National committee members have worked many long hours in promoting the interests of our association and in maintaining and upraising the standard of nursing care.

The President and members wish to record their congratulations and thanks for a job well done. We, in National Office, are most grateful for their assistance and cooperation.

International Code of Nursing Ethics

Adopted by the Grand Council of the International Council of Nurses, Sao Paulo, Brazil, July 10th, 1953. Approved by the Canadian Nurses' Association in convention in 1956.

Professional nurses minister to the sick, assume responsibility for creating a physical, social and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and coordinate their services with members of other health professions.

Service to mankind is the primary function of nurses and the reason for the existence of the nursing profession. Need for nursing service is universal. Professional nursing service is therefore, unrestricted by considerations of nationality, race, creed, color, politics or social status.

Inherent in the code is the fundamental concept that the nurse believes in the essential freedoms of mankind and in the preservation of human life.

The profession recognizes that an international code cannot cover in detail all the activities and relationships of nurses, some of which are conditioned by personal philosophies and beliefs.

1. The fundamental responsibility of the nurse is threefold: to conserve life, to alleviate suffering and to promote health.
2. The nurse must maintain at all times the highest standards of nursing care and of professional conduct.
3. The nurse must not only be well prepared to practise but must maintain her knowledge and skill at a consistently high level.
4. The religious beliefs of a patient must be respected.
5. Nurses hold in confidence all personal information entrusted to them.
6. A nurse recognizes not only the responsibilities but the limitations of her or his professional functions; recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.
7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.
8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.
9. A nurse is entitled to just remuneration and accepts only such compensation as the contract, actual or implied, provides.
10. Nurses do not permit their names to be used in connection with the advertisement of products or with any other forms of self-advertisement.
11. The nurse cooperates with and maintains harmonious relationships with members of other professions and with her or his nursing colleagues.
12. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.
13. In personal conduct nurses should not knowingly disregard the accepted patterns of behavior of the community in which they live and work.
14. A nurse should participate and share responsibility with other citizens and other health professions in promoting efforts to meet the health needs of the public — local, state, national and international.



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International Council of Nurses

TWELFTH QUADRENNIAL CONGRESS

Melbourne, Victoria, Australia
April 17-22, 1961

Preliminary Program

It is available for circulation from ICN headquarters and from the headquarters of the Royal Australian Nursing Federation. Copies will be sent in bulk on request to the headquarters of national member associations or to individual nurses.

Application Forms

Forms for attendance at the Congress and for accommodation in Melbourne, can be obtained from the National Office, Canadian Nurses' Association, 74 Stanley Avenue, Ottawa, Ont. The forms have to be returned, in duplicate, by national nurses' associations to the headquarters of the R.A.N.F. by November 1, 1960. A registration fee of five pounds sterling should accompany each application form.

Accommodation

It is earnestly requested that those planning to attend the Congress should *not* apply directly to hotels in Melbourne for accommodation. Indicate on the application form the type and price of accommodation required. Prices range from £4. 5. 0. per day (Australian pounds) for single room with private bath (bed and breakfast only) to £2. per day, without private bath (bed and breakfast). There will also be some accommodation available in nurses' residences of hospitals, and in private homes. This can be requested when completing the application form. (*N.B.* The Australian pound is equivalent to 16 shillings sterling, or $2.24 in U.S. currency.)

Professional Visits

Congress participants may indicate on their application forms the visit or visits they wish to pay in Melbourne, in order of preference. These visits may include general hospitals, midwifery hospital, specialized hospitals and/or institutions, public health services and nursing schools.

Excursions

Half-day or whole day excursions, available from Melbourne and which can be undertaken before or after the congress, are listed on the application forms. These include a tour of the city, or visits to country towns and rural areas within reach of Melbourne.

Social Events

Social events will include an evening reception for members of the Grand Council; a buffet banquet for all Congress participants, and an evening entertainment for student nurses arranged by student nurses of the hostess country.

New member associations, elected by the Grand Council, will be formally accepted in a special ceremony.

Student Nurses

Student nurses planning to attend the Congress must be sponsored by their national nurses' associations. Application forms and registration fees should be submitted, together with those of graduate nurse participants, to the Royal Australian Nursing Federation by *November 1st, 1960.*

ICN Board of Directors

The Board of Directors will meet in Wellington, New Zealand, on April 10, 11 and 12, 1961. It will meet again under its new officers on April 24, 1961. Following this meeting a special two-day conference is being arranged for executive secretaries of national member associations.

On the wall of the courtyard which surrounds Province House, **Halifax,** a tablet marks the site of the first printing press in British North America.—Dorothy Duncan

You have no more right to consume happiness without producing it than to consume wealth without producing it.

— G. B. Shaw

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1800 CALORIE DIETS

IMPORTANT! To achieve your weight goal . . . your daily diet must include foods from each of the lists shown . . . in the exact amounts indicated for your particular calorie pattern. Your calorie pattern requirements are indicated in the same color in each list. 1200 calories—red . 1600 calories (blue . 1800 calories green. You may eat these foods any time of the day you wish . . . however, it's advisable to divide them into 3 equal meals.

MEASURE CAREFULLY . . . USE STANDARD MEASURING CUPS AND SPOONS



VEGETABLE LIST

Each of the following food choices contains little carbohydrate, protein or calories.

1200 CALORIE DIET - Choice of any number

1600 CALORIE DIET - Choice of any number

1800 CALORIE DIET - Choice of any number

In Raw Form, Size of Serving Unlimited; Cooked, Size Serving ½ to 1 cup.

Asparagus	Eggplant	Dandelion
Broccoli	Lettuce	Kale
Brussels sprouts	Mushrooms	Mustard
Cabbage	Okra	Spinach
Cauliflower	Pepper	Turnip greens
Celery	Radishes	Sauerkraut
Chicory	Greens: Beet greens	String beans
Cucumber	Chard	Summer squash
Escarole	Collards	Tomatoes
		Watercress

OR You may choose from this vegetable list. Each of the following foods contains 7 grams carbohydrate, 2 grams protein, 35 calories.

1200 CALORIE DIET - Choice of any 2

1600 CALORIE DIET - Choice of any 4

1800 CALORIE DIET - Choice of any 4

One Serving Equals ½ cup.

Beets	Peas, green	Squash, winter
Carrots	Pumpkin	Turnips
Onions	Rutabagas	

BREAD LIST

Each of the following food choices contains 15 grams carbohydrate, 2 grams protein, 70 calories.

1200 CALORIE DIET - Choice of any 2

1600 CALORIE DIET - Choice of any 4

1800 CALORIE DIET - Choice of any 3

	Amount to Use
Bread	1 slice
Biscuit, roll (2" diameter)	1
Muffin (2" diameter)	1
Cornbread (1½" cube)	1
Cereals, cooked	½ cup
Dry, flake and puff types	¾ cup
Rice, grits, cooked	½ cup
Spaghetti, noodles, cooked	½ cup
Macaroni, cooked	½ cup
Crackers, graham (2½" sq.)	2
Oysterettes (½ cup)	20
Saltines (2" sq.)	5
Soda (2½" sq.)	3
Round, thin	6
Flour	2½ tablespoons
Vegetables (lima, navy, split peas, cowpea, etc.)	½ cup
Beans and peas, dried, cooked	½ cup
Baked beans, no pork	¼ cup
Corn	⅓ cup
Popcorn	1 cup
Parsnips	⅔ cup
Potatoes, white	1 small
Potatoes, white, mashed	½ cup
Potatoes, sweet or yams	¼ cup
Sponge cake, plain (1½" cube)	1
Ice cream (omit two fat choices)	½ cup

MILK LIST

Each of the following food choices contai grams carbohydrate, 8 grams protein, 10 gra and 170 calories.

1200 CALORIE DIET - Choice of an

1600 CALORIE DIET - Choice of an

1800 CALORIE DIET - Choice of an

	Amount
Whole milk (plain or homogenized)	
*Skim milk	
Evaporated milk	
Powdered whole milk	
*Non-fat dry milk solids	
Buttermilk (made from whole milk)	
*Buttermilk (made from skim milk)	

You can use the milk on your meal plan to in coffee, on cereal, or with other foods.

*Skim milk products contain less fat. When used in whole milk add 2 fat choices to get the same food val

FAT LIST

Each of the following food choices contains 5 fat, 45 calories.

1200 CALORIE DIET - Choice of an

1600 CALORIE DIET - Choice of an

1800 CALORIE DIET - Choice of an

	Amount
Butter or margarine (1 small pat)	1 teasp
Bacon, crisp	1 slice
Cream, light	2 table
Cream, heavy	1 table

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eese	1 tablespoon
4" diameter)	¼
essing	1 tablespoon
se	1 teaspoon
king fat	1 teaspoon
	6 small
	5 small

LIST

the following food choices contains 10 bohydrate and 40 calories.

[illegible] DIET - Choice of any 2

CALORIE DIET - Choice of any 5

CALORIE DIET - Choice of any 5

	Amount to Use
diameter)	1 small
e	½ cup
fresh	2 medium
dried	4 halves
	½ small
ies	1 cup
es	1 cup
ies	1 cup
s	⅔ cup
e (6" diameter)	¼
	10 large
	2
	2 large
l	1 small
	½ small
juice	½ cup
	12
e	¼ cup
melon, medium	⅛
	½ small
	1 small
ice	½ cup

Papaya	½ medium
Peach	1 medium
Pear	1 small
Pineapple	½ cup
Pineapple juice	½ cup
Plums	2 medium
Prunes, dried	2 medium
Raisins	2 tablespoons
Tangerine	1 large
Watermelon	1 cup

You may use your fruit fresh, dried, cooked, canned or frozen as long as no sugar has been added.

MEAT LIST

Each of the following food choices contains 7 grams protein, 5 grams fat, 75 calories.

[illegible] DIET - Choice of any 4

1600 CALORIE DIET - Choice of any 6

1000 CALORIE DIET - Choice of any 6

	Amount to Use
Meat and Poultry (*medium fat*) 3-4 Oz. Average Serving (Beef, lamb, pork, liver, chicken, etc.)	1 ounce*
Cold cuts (4½" x ½") Salami, Minced Ham, Bologna, Liverwurst, Luncheon Loaf	1 slice
Frankfurter (8-9 per lb.)	1
Egg	1
Fish: haddock, flounder, bass, 3-4 Oz. Average Serving	1 ounce*
Serving Salmon, tuna, crab, lobster	¼ cup
Shrimp, clams, oysters, etc.	5 small
Sardines	3 medium
Cheese, Cheddar type	1 ounce
Cottage	¼ cup
Peanut butter	2 tablespoons

**Equals 1 Meat Choice; 3 oz. serving uses 3 Meat List Choices.*

"BETWEEN-MEAL" SNACK LIST

Each of the following "Between-Meal" snacks is made with Knox—the *real* unflavored gelatine. There are only 28 calories in each envelope of High-Protein Knox.

[illegible] CALORIE DIET
1600 CALORIE DIET
1000 CALORIE DIET

Take Knox Drink 3 times daily

Take the Knox High-Protein Drink ½ hour before meals as a cold drink *(with Fruit Juices)*. Empty 1 envelope Knox Gelatine in ¾ glass of orange juice, other fruit juices or water, not iced. Let liquid absorb the gelatine. Then stir briskly. Drink quickly. If it thickens, add more liquid, stir again.

OR

As a hot drink *(with Bouillon)*. Sprinkle 1 envelope Knox Gelatine on ¼ cup cold water to soften. Add 1 bouillon cube and ¾ cup boiling water. Stir until gelatine and bouillon cube are thoroughly dissolved. ¾ cup of any very hot broth may be used in place of bouillon.

After you have reached your weight goal . . . take Knox "Booster" Drink (with milk) to maintain weight and to supply additional protein. 1 (8 oz.) glass contains 15 grams protein, 130 calories. In an 8 or 10 oz. dry glass, thoroughly mix 1 envelope Knox Gelatine with 3 to 6 tablespoons *instant* non-fat dry milk (varies with brand). Fill with cold water. Stir briskly until milk thoroughly dissolves. Drink quickly.

OD EXCHANGES

1. are authoritative[1]
2. eliminate calorie counting
rovide a wide variety of food
4. assure a balanced intake
rotein*, carbohydrate, and fat

1. The Food Exchanges Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

**Knox Gelatine is an economical source of the α-amino acid lysine.*

In Memoriam

Ruby Allen, a graduate of the Collingwood, Ontario, General and Marine Hospital, died in New York City on February 29, 1960.

* * *

Edna Mary Anderson who graduated from a school of nursing in New London, Connecticut, U.S.A., died on March 16, 1960. She had done private nursing in Ottawa for many years.

* * *

Louise (Komph) Barrett who graduated from McKellar General Hospital, Fort William, Ont. in 1913 died in a car accident on January 16, 1960. She had served with the Canadian Army Medical Corps during World War I.

* * *

Margaret (McCulloch) Bateson, a 1944 graduate of the Nicholls School of Nursing, Civic Hospital, Peterborough died in a fire that took the lives of her four children as well. In tribute to her, the Campbellford, Ont. branch of the alumnae association has named their bursary "The Margaret Catherine Bateson Memorial Bursary."

* * *

Albina De Grandpré, a graduate of Notre Dame Hospital, Montreal in 1925, died on March 17, 1960. She had retired in 1959 from the Montreal city health service.

* * *

Madeline Marie (Verchere) Mathers who graduated from St. Paul's Hospital, Vancouver in 1934 died on March 15, 1960 from injuries received in an accident.

* * *

Mary (Grigor) Michie who graduated from a New Zealand hospital died in Edmonton on August 30, 1959. She had served with the New Zealand expeditionary forces during World War I and received the Royal Red Cross and the Mons Star in recognition of her work.

* * *

Beverley Grace Simms, a graduate of the Royal Columbian Hospital, New Westminster, died on March 23, 1960 in a tragic accident.

* * *

Sister Maria Foucher who graduated from the General Hospital, Vegreville, Alta. in 1918, died on September 19, 1959. For the past 10 years she had been a member of the nursing staff of St. Louis Hospital, Bonnyville, Alta.

* * *

Sister Marcellin, a graduate of St. Joseph's Hospital, Three Rivers, P.Q., in 1922 died on March 16, 1960. She was 85 years of age. During her lifetime she had been very active in nursing education, having opened the school of nursing, Sacred Heart Hospital, Cartierville, P.Q. and reorganized the school at St. Joseph's Hospital, Three Rivers.

* * *

Bessie Soutar who graduated from Belleville General Hospital, Ont. in 1925 died in December, 1959. She had been nurse-in-charge of the Sudbury branch of the V.O.N. for many years.

* * *

Elizabeth Catherine Ostler Williams who graduated from Kingston General Hospital, Ont. in 1954, died in October 1959. She had been on the staff of the hospital following completion of her training.

A MEMORIAL

In tribute to the outstanding contribution made by **Eileen (Snowden) Ramsay** to public health services in Quesnel, B.C. and the surrounding territory, the town's new health unit will be named the Eileen Ramsay Memorial Health Centre.

Mrs. Ramsay, who founded the Cariboo Health Unit and served in Quesnel for the past 14 years, died recently.

The **Halifax dockyard** built in 1759 and since remodeled, contains relics of great interest. Captain James Cook superintended the erection of the first buildings.

— Dorothy Duncan

* * *

Old charts used by Lord Nelson may be seen in the Legislative Library in Province House, Halifax. — Dorothy Duncan

Knowledge is the only instrument of production that is not subject to diminishing returns. — J. M. Clark

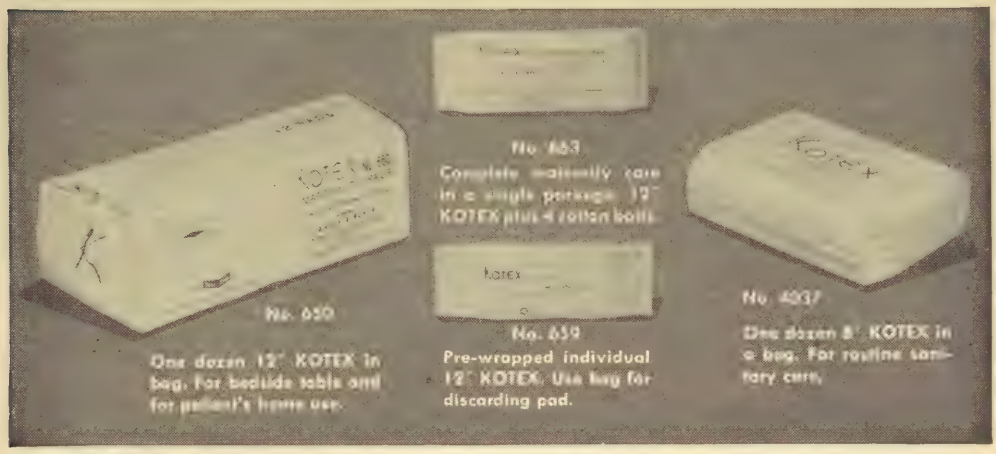
* * *

Life is adventure in experience, and when you are no longer greedy for the last drop of it, it means no more than that you have set your face . . . to the day when you shall depart. — D. C. Peattie

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Book Reviews

Patient Care and Special Procedures in X-Ray Technology by Carol Hocking Vennes, R.N., B.S. and John C. Watson, R.T. 203 pages. The C. V. Mosby Company, St. Louis, Mo. 1959. Price $5.75.
Reviewed by Mr. G. A. Wilkinson, R.T., B.Sc., Chief Technician, Royal Victoria Hospital, Montreal.

A nightingale is defined as a small reddish-brown migratory bird which sings melodiously and powerfully both by night and by day. During the Crimean War a very special Nightingale began a song of compassion for the suffering of mankind that has continued to grow more powerful with the passing of each night and each day. Throughout this land and others many nightingales, not all small nor reddish-brown, have migrated to sing their song around the world.

A roentgen is defined as a small unit of ionizing radiation. It too has sung melodiously and with increasing power and has joined the nightingales in carrying its song around the world. During the years of common migration, there have been many times when the two songs blended in complete harmony, many times too when they clashed in chaotic discord. Such discord is usually the result of failure to learn the words of the other's song.

This text offers both the nurse and the technician the opportunity to learn the words, and the actions, of each other's song. The increasing complexity of medical and surgical nursing procedures and of radiological procedures, make it mandatory for the nurse and the technician to be aware of each function in procedures affecting both. Prior to writing this review, I sought the opinion of the nurse in our radiological department as to the value of this book to the nursing profession. Her reply was "I think the book is very good. I did not realize how little I knew about radiological procedures until I commenced working in the department. I feel that every student nurse should be given at least a week of rotation in the radiological department to observe the procedures and gain an understanding of the general method of operation."

I recommend this book, without reservation, as a very necessary addition to the library of every radiological department. I believe sincerely, that every nursing department, and particularly every nursing school, should include it in the reference library. The authors have forged a new link in the chain of medical knowledge involving the nurse and the x-ray technician; knowledge which should weld the nurse and the x-ray technician closer together in their common purpose to achieve better care for the patient.

History and Trends of Professional Nursing by Deborah MacLurg Jensen, R.N., B.S., M.A. 610 pages. The C. V. Mosby Company, St. Louis, Mo. 4th ed. 1959. Price $5.25.
Reviewed by Miss Mary Fagan, nursing instructor, St. Rita's Hospital, Sydney, N.S.

The content is presented in a clear and brief manner. It does not tire you with unnecessary detail, but presents important facts tersely without any loss of clarity. It makes us cognizant of the rapid and constant changes in nursing today. It helps us to understand the necessity of studying the historical background of the past, if we are truly to understand our profession. The author reiterates that we should not interest ourselves merely in dates and events but should get to the crux of the matter which, in all history, is the principles for which great men and women have fought.

It is a very good text for the student. It seems to have accomplished one of its purposes, "To teach the student nurse to appreciate the value of the professional education she is receiving, to understand the great responsibility laid upon her shoulders and the high purpose which she is to serve."

Undoubtedly it would have greater appeal to Canadian nurses if more information on Canadian nursing was included.

Fundamentals of Nursing by Elinor V. Fuerst, R.N., M.A. and LuVerne Wolff, R.N., M.A. 662 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 2nd ed. 1959. Price $5.00.
Reviewed by Miss Marguerite Schumacher, advisor to schools of nursing, University of Alberta, Edmonton.

The first edition of this book was written in 1956 for students in the basic nursing course. The second edition is again designed to meet the needs of the same group. The main purpose of the book is to stimulate



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the student to develop her initiative and a plan of action based on scientific principles.

To achieve the objective the authors have retained the method of presenting procedures and emphasizing the underlying principles to explain each action. The revised unit on the learner and the learning process is much more readable and practical for the student. The unit on the spiritual needs of the patient has been included with the diversional needs. Inasmuch as these are two rather different topics it would have been better to separate them. Diversional needs, which include recreational and occupational therapy, could have been included as part of the unit on rehabilitation.

One of the main differences in the second edition is the constant presentation of the patient as an individual with *emotional* needs as well as *physical* ones. Factual material has been brought up-to-date and trends, not only in nursing but also in our society, are brought into focus.

Each unit has a brief introductory section providing an orientation to the topic. Study situations are listed in each unit. These are most interesting and thought-provoking. They could well be used by instructors to plan and teach this course. Although all of the tables quoted in the various illustrations are American figures there is no doubt that many Canadian figures could be obtained. As a teaching aid this text is a valuable adjunct for the instructor.

Medicine for Nurses by M. Toohey, M.D., M.R.C.P., D.C.H. 663 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 4th ed. 1959. Price $5.00.

Reviewed by Mrs. Shirley Biccum, clinical instructor, Grace Hospital, 200 Arlington St., Winnipeg.

The preface states the author's purpose: "I have tried to make it (the text) as comprehensive as possible so that it will not only help the nurse during her training but also serve as a reference book afterward." The author admits that he has not attempted to include nursing care. He feels that this is better learned by ward experience, and that it is included in other nursing books.

In this latest edition the text has been brought up-to-date and includes new treatments, tests and drugs, such as the use of radioactive isotopes. The author introduces the nurse to medicine with a short review of pathology, the effects of disease upon the body, and the general causes of disease.

The main part of the book discusses the major medical conditions arranged according to the body systems that they affect. Infectious diseases are included. The remainder contains shorter sections on many topics related to medicine. Drugs are discussed under the heading "Important Drugs," and are listed according to chemical and trade names and their uses. First aid measures are included in a chapter on "Coma and Poisoning."

Another chapter briefly points out facts that the nurse must keep in mind in doing her daily work. For example, such topics as "the pulse," "blood transfusions," and "the patient as an individual" are discussed. A chapter written by a British psychiatrist relates to psychological medicine. The nurse is introduced to the psychological development of the individual, and to some of the psychoneurotic disorders. The psychologic effects of illness are stressed.

This book contains excellent photographs, some of them in color. Many original sketches have been used to show simply but dramatically the important points. Many chapters are introduced by a review of the related anatomy and physiology. Detailed summaries follow the most important chapters, for example, "Diseases of the Circulatory System." Most chapters are also followed by outlines listing routine procedures, tests and drugs used in the diseases discussed. Review questions and suggested reference readings have not been included.

The lack of stress on nursing care places the emphasis of this book on disease conditions rather than on the care of the patient. For this reason its value as a classroom text is limited. However, its broad scope in other respects makes it valuable as a reference in a nursing library. It would also prove very useful as a ward library reference for both graduates and students.

WHO Technical Report Series No. 177, Social Psychiatry and Community Attitudes. 40 pages. World Health Organization, Palais des Nations, Geneva. 1959. Price 30 cents.

Reviewed by Miss Katherine MacLennan, director, nursing education, Riverside Hospital, Charlottetown, P.E.I.

This comprehensive report, of interest to the laity as well as professional workers in the health field, considers the role of social psychiatry in combatting mental illness and the way in which its application is affected by community attitudes.

Social psychiatry is defined and the function of the social psychiatrist is described.

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The main bulk of the report considers community attitudes from such approaches as types, factors affecting them, reaction to different kinds of mental illness, attitudes to treatment facilities, and to various types of psychiatric treatment. Results of surveys and studies are explained. It is apparent that attitudes towards mental illness are improving, although more rapidly in some countries than in others. In the recommendations for action, broad principles are formulated to act as a guide in planning an effective campaign directed at changing community attitudes. The recommendations on research stress the importance of the use of proper methods.

This report is of particular interest to nurses because it acquaints them with existing attitudes toward mental illness and thus enables them to take their places with other potential educators in the field of mental health.

Some Like it Hot

One small aspect of hospital service seems to deteriorate in direct proportion to the size of the institution. The larger the hospital — the colder the tea!

A patient at the far end of the corridor on the umpteenth floor of a city hospital can be sure that when his tea arrives it will not burn his tongue. The diet kitchen is probably in a subterranean cavern half a mile from the furthermost patient — as the tray trolley travels. Even a special delivery service would not improve matters to any appreciable extent.

Today, with tea bags and electric kettles it should be feasible to pour boiling water into a teapot in the corridor a moment before carrying the tray to the patient. A nurse might take an extra few seconds to warm the teapot and the cup with hot water before serving — as any tea granny knows should be done.

Small hospitals do not have this problem to such a severe degree. But our hospitals are being increased in size year by year.

Durham Chronicle

* * *

The snail, which everywhere doth roam
Carrying his own home still, still is at home,
Follow (for he is easy paced) this snail,
Be thine own palace, or the world's thy jail.

— JOHN DONNE

* * *

Each is given a bag of tools,
A shapeless mass,
A book of rules;
And each must make,
Ere life is flown,
A stumbling-block
Or a stepping-stone.

— R. L. SHARPE

* * *

Man is the only animal that blushes
Or needs to — MARK TWAIN

The administration of intravenous solutions by nurses has been approved by the College of Physicians and Surgeons of Saskatchewan, the Saskatchewan Hospital Association and the Saskatchewan Registered Nurses' Association under the following conditions:

That intravenous infusions be considered a nursing procedure;

that the practice of this procedure by nurses be subject to the written approval of the Medical Board and the Board of Trustees of the individual hospital or agency;

that nurses be allowed to administer all intravenous solutions including blood and blood substitutes but excluding drugs;

that nurses be permitted to administer drugs into intravenous bottles only but not directly into the drip, tubing or vein;

that the medical staff of each hospital or agency prepare a written list of additives which can safely be introduced into the intravenous bottle by nurses;

that all students receive instruction and practice under supervision during the last six months in the school of nursing;

that nursing service administrators in hospital and other health agencies assume responsibility in providing adequate teaching and supervision of intravenous procedures to the graduate nurses under their supervision;

that each hospital or agency formulate a policy concerning the administration of intravenous solutions by private duty nurses.

News Bulletin, S.R.N.A.

* * *

If a person is taking chlorpromazine, he must be very careful about drinking alcoholic beverages — the former increases the physiological effects of the latter.

Health Bulletin, North Carolina State Board of Health.

* * *

The preservation of health is a duty. Few seem conscious that there is such a thing as physical morality. — SPENCER

* * *

He that is of merry heart hath a continual feast. — PROVERBS

* * *

The Ovens are a series of strange caverns along the rugged shoreline at Cunard's Cove. One legend has it that an Indian paddled his canoe into one of the caverns at low tide and finally emerged on the other side of the peninsula at Annapolis Royal. No one really knows how deeply the caverns penetrate since the sea is generally rough at the entrance to them. *Off-Trail in Nova Scotia*

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— SOCRATES

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If misery loves company, misery has company enough. — THOREAU

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Instructor, Psychiatric Clinical (to teach affiliating students in 8-wk. program) 1500-bed active treatment hospital conducting an accredited school of nursing. Salary range $4,320 to $5,160 per annum, 40-hr. wk., civil service holiday, sick leave & pension benefits. Residence with board, if desired, $30 per mo. Apply stating qualifications & experience to: Superintendent of Nurses, Provincial Mental Hospital, Department of Public Health, Ponoka, Alberta.

Registered Nurses (2 Immediately) for 15-bed hospital. State salary. Phone or write: Smoky Lake Municipal Hospital #73, Smoky Lake, Alberta.

Registered Nurse for rural Health Unit in Alberta, Canada. Salary range according to training & experience. Transportation is provided on duty & to a limited extent off duty. Provision is made for sick leave & holidays & a pension plan is available. Apply to: Dr. K. A. Barrett, Medical Officer of Health, Minburn-Vermilion Health Unit, **Vermilion,** Alberta.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital, centrally located between two very good summer resorts etc. Salary schedule according to suggested A.A.R.N. namely $275 - $300 & adjusted according to experience since graduation. Living in accommodation available at $30 per mo. & Blue Cross on a 50-50 basis. Apply: Mrs. J. Bergquist R.N., Matron, Municipal Hospital # 43, Bentley, Alberta.

Registered General Duty Nurses for busy 45-bed hospital, with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr.wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

General Duty Nurses — Salary $3,480 - $4,080 per annum, 40-hr. work wk., Civil Service holiday, sick leave & pension programs. Apply to: Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurses starting June 1st. for summer relief & steady employment for 54-bed hospital, 40-hr. wk., gross salary $278.60 per mo. with 3 annual increases less $35 maintenance, 1-mo. vacation after 1-yr. service. Voluntary pension plan & compulsory M.S.I. & Blue Cross Groups in operation. Apply: stating references & experience if any, to: Matron, Municipal Hospital, Vermilion, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

Operating Room Nurse (1) for 34-bed hospital. Salary $280-$310 per mo., 40-hr. work wk., train fare from any point in Canada will be refunded if employed for 1-yr. For full particulars apply to: Municipal Hospital, Two Hills, Alberta. Phone 335.

BRITISH COLUMBIA

Clinical Instructor in Surgical Nursing. Degree or diploma required & experience preferable. Salary $355 per mo., credit for past experience. Annual increment, cumulative sick leave, 28-days annual vacation, B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Clinical Instructress (with Degree or Certificate), **Operating Room Nurses** (Postgraduate Training), **General Duty Nurses** for 450-bed hospital, B.C. registration required. Salaries & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

Registred Nurses for new 250-bed accredited hospital, General Duty all departments. Salary $270, $285 - $342. 1-mo. vacation plus 10 statutory holidays after 1-year. 50% medical coverage. Implementation of superannuation expected this year. 6-mi from the centre of Vancouver city. Write or wire: Director of Nursing, General Hospital, Burnaby, British Columbia.

Registered Nurses (2) for 45-bed hospital. **Registered Nurses** (2) for summer relief. Salary $285 per mo., 40-hr. wk., 28 days vacation after 1-yr. service, 10 statutory holidays, sick leave 1½-days per mo. cumulative to 120-days, nurses' home available. Apply: Matron, R. Miller, Memorial Hospital, Fernie, British Columbia.

Registered Nurses (3) immediately for present 39-bed hospital — new 50-bed hospital & new nurses' residence under construction. Salary $285 per mo. with annual increments if B.C. registered; $270 per mo. non B.C. registered. 1-mo. annual vacation, sick leave benefits. Board & room $50 per mo. Please address all replies to: Director of Nursing, Terrace & District Hospital, P.O. Box 1297, Terrace, British Columbia.

Registered Nurses (3) for 30-bed hospital in Central B.C. on the Jasper-Prince Rupert Highway, 70-mi. from Prince George. Salary $290 per mo., 10 legal days with pay per year; 1½-days sick leave per mo., 28-days vacation after 1-yr. Laundering of uniforms by hospital; modern nurses' residence $50 per mo. Kindly apply giving qualifications & references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

General Duty Nurses for small active hospital. Salary $260 for unregistered, $275 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for modern 154-bed General Hospital Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270 Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric & General Duty Nurses (Position available immediately) for new modern 125-bed hospital & nurses' residence in the heart of British Columbia. Starting salary B.C.R.N. $285. For further particulars write: Nursing Supervisor, Prince George & District Hospital, Prince George, British Columbia.

Male Operating Room Nurses (Registered in British Columbia) ability to carry responsibilities of a circulating nurse essential. Experience preferred. Salary $285-$342; differential for postgraduate work. 40-hr. wk., rotating shifts, no "call" work; 4-wk. annual vacation, cumulative sick time, health plan. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. **Registered Nurses** basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses (2). Salary: $285 per mo. Room, board & laundry: $40 per mo. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with four annual increments of $14; 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Operating Room Nurses for 125-bed hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. Apply: Prince George & District Hospital, Prince George, British Columbia.

MANITOBA

Matron for 35-bed General Hospital, in southern Manitoba. Duties to start immediately. Starting salary $350, room & board charged at $45 per mo., no charge for laundering separate residence, pleasant staff to work with. Apply: F. E. Dueck, Administrator, Altona District Hospital # 24, Box 660, Altona, Manitoba.

Registered Nurse (1-Immediately) for 11-bed hospital. Salary $310 per mo. with increments, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurse for 10-bed rural hospital, starting salary $300 per mo., with semi-annual increments. Other valuable benefits. Opportunity of becoming Matron if interested. Apply: Secretary-Treasurer, Box 235, Fisher Branch, Manitoba.

Registered Nurses (2) Starting salary $295 per mo., new nurses' residence in hospital situated 100-mi west of Winnipeg, Manitoba, on No. 2 Highway. Excellent staff policy in effect, & copies available upon request. Please send applications to: Miss Jean Simpson, Matron, Glenboro Medical Nursing Unit #16B, Glenboro, Manitoba.

Registered Nurses (2) for 20-bed hospital. Salary: $300 per mo. gross. 40-hr. wk. with 4 annual increments of $10. 3-wk. vacation with pay after 1 full yr. employment, 4-wk. after 2 full years. Sick leave, 1 day for each full mo. of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Apply: Matron or A.C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurses for 29-bed hospital, 35-mi. south of Winnipeg. 42-hr. wk. Starting salary $315; $5.00 increase 6-mo. the first year, $10 yearly thereafter to a maximum of $355. Annual vacation with pay plus statutory holidays. Residence accommodation available. Matron, DeSalaberry Hospital, St. Pierre, Manitoba.

Registered & Licensed Practical Nurse for General Duty. Gross monthly salary $310 for R.N., — $220 L.P., less $45 for full maintenance. Apply: John Hiscock, Secretary Treasurer, Medical Nursing Unit, Baldur, Manitoba.

General Duty Registered Nurses & Registered Nurses for Supervisory duties at Selkirk General Hospital, Selkirk, Manitoba. New, well-equipped hospital, close to Winnipeg, hourly bus schedule. Salary in keeping with Manitoba schedules. Apply: P.O. Box 5000, Selkirk, Manitoba.

NEW BRUNSWICK

Science Instructor for the Moncton Hospital School of Nursing which has a yearly enrollment of 40 students. Salary based on qualifications, 40-hr. wk., good personnel policies. Apply to: Director of Nursing, The Moncton Hospital, Moncton, New Brunswick.

Assistant Head Nurse for psychiatric division. Apply stating qualifications & experience to: Director of Nursing, Saint John General Hospital, Saint John, New Brunswick.

NOVA SCOTIA

Supervisor (Floor) & Assistant Superintendent for small modern General Hospital situated on the beautiful south shore of Nova Scotia. Starting salary $280 gross, $40 deduction for board. Pension plan pending. Course in Supervision preferred. Must have had Supervisory experience. **Also O. R. Nurse** required. Starting salary $250. Apply: Superintendent, Fisherman's Memorial Hospital, Lunenburg, Nova Scotia.

Operating Room Supervisor (Immediately) Starting salary $3,000 p.a., 40-hr. wk. Apply giving full particulars to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

Registered Nurses for 80-bed hospital, starting salary $220 with annual increments, living accommodation available. Apply: Director of Nursing, Highland View Hospital, Amherst, Nova Scotia.

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

THE SARNIA GENERAL HOSPITAL

OFFERS EXCELLENT OPPORTUNITIES FOR

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

The hospital is modern, fully approved (J.C.A.H.) with plans for an expansion program to be completed over the next five years.

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

Salary Schedule:

for Registered Nurses — $265 per month to $324 per month.

for Certified Nursing Assistants — $182 per month to $215 per month.

Apply to:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

ONTARIO

Director of Nursing for 105-bed hospital. No school of nursing but C.N.A. course being considered. Degree in nursing administration an advantage. Salary open, personnel policies include 40-hr. wk., pension plan, sick leave. Mark envelope "Director of Nursing", Apply: St. Andrews Hospital, Midland, Ontario.

Director of Nursing for modern 100-bed non-teaching, General Hospital located in progressive town of 11,000 in beautiful Rideau Lakes region. 1-hr. drive to Capital city. Live in or out, pension plan, no construction problems. Salary open & dependent upon qualifications & experience. References required. Apply giving full particulars to: Administrator, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Assistant to Director of Nursing Service to work afternoon & evening shifts rotating bi-weekly, 5-days per wk., in 100-bed active General Hospital. Excellent personnel policies & salary scale. Employer participation in pension plan. Personal interview will be arranged. Forward enquiries to: Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

Floor Supervisor & General Duty Nurses for 50-bed hospital, 40-hr. wk., 8 statutory holidays, comfortable residence. Meaford is situated on Georgian Bay & is a tourist town. For further information apply to: Director of Nurses, General Hospital, Meaford, Ontario.

Supervisor of Public Health Nursing required by Peel County Health Unit, a rural-urban area with a population of 100,000 near Toronto. Applications are invited from qualified nurses for this appointment, Present staff 20-nurses. For details write: Dr. D. G. H. MacDonald, Medical Officer of Health, 44 Nelson Street West, Brampton, Ontario.

Female Superintendent for 30-bed modern hospital, located in the Town of Matheson — Staff 28. To be responsible for Supervision of Staff; and all phases of hospital operation — (except accounting). Separate suite of rooms for Superintendent — beautiful location. Duties to commence May 1, 1960. Please apply, stating age, qualifications & salary expected, to M. D. Kaye, Chairman of Board of Directors, Bingham Memorial Hospital, Matheson, Ontario. — Phone 375.

Assistant Superintendent, Registered Nurse for 73-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Science Instructor; Clinical Teachers for pediatric & medical-surgical departments; **General Duty Nurses** for surgical nursing. Apply: Director of Nursing, Hotel Dieu Hospita, Kingston, Ontario.

Clinical Instructor for the Plummer Memorial Public Hospital School of Nursing. Address applications to the: Administrator, Plummer Memorial Public Hospital, Sault Ste. Marie, Ontario.

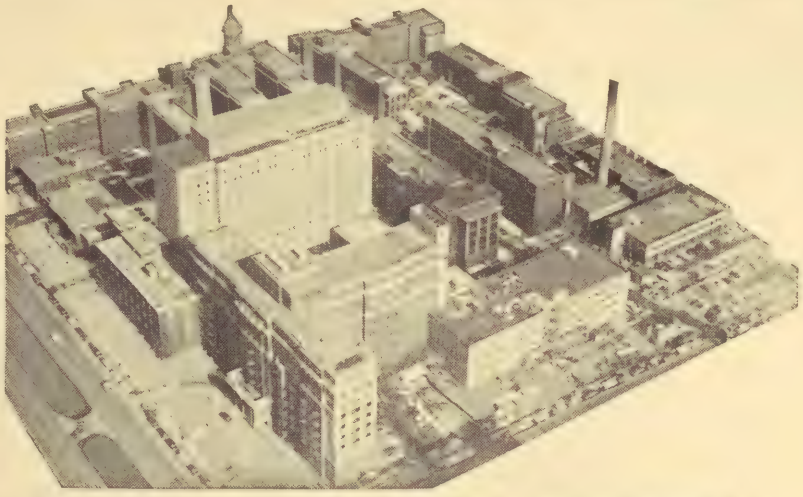
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OF
PUBLIC HEALTH

1. Nurses with Midwifery Certificate for outpost hospitals.
   Salary: $337 - $410 per month.
   Living accommodation provided. File No. c/c 6465
2. Qualified Public Health Nurses for generalized program in health regions.
   Salary: $312 - $379 per month. File No. c/c 6468
3. Registered Nurses for public health work.
   Salary: $288 - $350 per month. File No. c/c 6468

Nurses may apply for bursaries to obtain public health nursing certificates following field work.

BENEFITS: Three weeks holiday, three weeks accumulative sick leave allowance annually with pay, excellent pension and group life insurance plans and other benefits.

APPLICATIONS: Forms and further information available at Public Service Commission, Legislative Building, Regina.



TORONTO GENERAL HOSPITAL
invites applications from
REGISTERED NURSES and CERTIFIED NURSING ASSISTANTS
Rewarding Experience — Excellent Personnel Policies

For information write to:
DIRECTOR OF NURSING, TORONTO GENERAL HOSPITAL, TORONTO 2, ONTARIO

Instructors for Medical-Surgical Nursing, & Nursing Arts, in school of nursing, with new facilities opened this year. Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Registered Laboratory Technician for new 58-bed hospital with new equipment in laboratory. Apply to: The Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical, Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation. Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses for 100-bed active General Hospital. Good salary, personnel policies include 5-day work wk., 14-days paid sick leave accumulative, 3-wk. vacation & 7 statutory holidays. Employer participation in pension plan. Apply to: Director of Nursing. The Cottage Hospital, Pembroke, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience $5.00 increment every 6-mo. 44-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo. 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurse for active rehabilitation centre. Interesting & unusual work with minimum shifts. Phone or Write: Lyndhurst Lodge Hospital. 153 Lyndhurst Avenue, Toronto 4, Ontario. Phone WA-3-0928.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for 92-bed General Hospital, excellent personnel policies, 5-day wk., residence accommodation if desired. Minimum starting salary $270. Apply: Director of Nursing, I.O.D.E. Memorial Hospital, Windsor, Ontario.

Registered Nurses & Certified Nursing Assistants for well equipped 60-bed hospital in small, friendly community on main line of C.P.R. Liberal personnel policies with salaries above R.N.A.O. recommendations. Attractive living accommodation available. Apply: Director of Nursing, Lady Minto Hospital, Chapleau, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses & Certified Nursing Assistants for a Medical Unit (non-Tuberculous), 5-day wk., 4-wk. annual vacation, pension plan. Residence accommodation available. Apply: Director of Nursing, Niagara Peninsula Sanatorium, St. Catharines, Ontario.

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 58-bed hospital, North-Western Ontario tourist area town, midway Fort William & Winnipeg. Gross salary $285 per mo. with increments & consideration for past experience. Excellent personnel policies, pleasant working conditions. Single room residence accommodation. Apply: Director of Nursing, Dryden District General Hospital, Dryden, Ontario.

Registered Nurses for General Duty on Surgical Floor in 163-bed Sanatorium. Good salary & personnel policies. Residence accommodation available. Apply: Director of Nurses, Sudbury & Algoma Sanatorium, P.O. Box 40, Sudbury, Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk., good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

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WINNIPEG 3, MANITOBA

OPERATING ROOM SUPERVISOR

FOR 200-BED HOSPITAL

DUTIES TO INCLUDE ADMINISTRATION OF DEPARTMENT AND TEACHING OF THE STUDENTS DURING THEIR OPERATING ROOM EXPERIENCE.

POSTGRADUATE STUDY REQUIRED.

For details apply to:

DIRECTOR OF NURSING, GENERAL HOSPITAL, CORNWALL, ONTARIO

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Staff Nurses for all departments (including Operating-Room); 5-day wk; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

Registered General Staff Nurses for all services, R.N.A.O. salary schedule, increments every 6-mo. 40-hr. wk., differential for evening & night duty. Excellent personnel policies & pension plan. Apply to the: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 73-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305 for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing. Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 50-bed hospital. Salary $270, 5-day wk., summer & winter sports area. Apply: Director of Nursing, Huntsville District Memorial Hospital, Huntsville, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for modern 42-bed hospital. Starting salary: new graduates, $275; 1 or more year's experience, $285. Annual increments; shift differential bonus; Ontario registration necessary for maximum salaries. 40-hr. wk. Residence accommodation available. Apply to: Nursing Supervisor, General Hospital, P.O. Box 909, Sioux Lookout, Ont.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses. District Memorial Hospital, Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Graduate Nurses, Certified Nursing Assistants for General Duty for new 58-bed hospital. For information please write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurses for a generalized program, rural & urban. Minimum salary $3,500 — allowance for experience. Car allowance, pension plan, shared hospital insurance & P.S.I. 1-mo. vacation. Apply to: Dr. G. Murray Fraser, Director, Brant County Health Unit, Brantford, Ontario.

Public Health Nurses (Qualified) generalized program Minimum salary $3,417; annual increment $150, liberal transportation allowance & other benefits. Apply to: A. E. Thoms M.D., Director, Leeds & Grenville Health Unit, Brockville, Ontario.

Public Health Nurses (qualified). Generalized program includes some bedside nursing. Salary $3,200-$4,250, annual increment $150, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses (Kitchener Department of Health, September 1960). For further information write: Miss Olga Friesen, Department of Health, 9 Ahrens Street East, Kitchener, Ontario.



Residence, Cook County School of Nursing

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COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

THE VANCOUVER GENERAL HOSPITAL

requires

PEDIATRIC, OPERATING ROOM & PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff. Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department, Vancouver General Hospital, Vancouver 9, British Columbia.

THE MONTREAL GENERAL HOSPITAL

MONTREAL

requires a

POSTGRADUATE CLINICAL INSTRUCTOR

Operating Room

For further information apply to:

THE DIRECTOR OF NURSING,
THE MONTREAL GENERAL HOSPITAL,
MONTREAL, QUEBEC

Public Health Nurses (qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,750; starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr., pension plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario.

Public Health Nurses (Qualified) for generalized program, urban & rural. Salary $3,500-$4,250; annual increment $150, pension plan, P.S.I., 4-wk. vacation. Apply: Archie F. Bull, M.D., D.P.H., Medical Officer of Health. Halton County Health Unit, Milton, Ontario.

Public Health Nurses (Qualified) required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurse for September 1960 (Preston Board of Health). For further information write: Mrs. Bertha M. Young, Health Centre, 566 Duke Street, Preston, Ontario.

Public Health Nurses for generalized nursing program. Salary range $3,500-$4,400, annual increment $150, salary based on experience. 5-day wk., vacation 4-wks., pension plan & P.S.I. available. Car allowance or transportation provided. Apply to: Director, St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurse for generalized service in urban area. Personnel policies on request. Apply: Dr. J. E. Gimby, MOH. 235 Wellington Street West, Sault Ste. Marie, Ontario.

Public Health Nurses for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500-$4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave - 1½ days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Uniform allowance - Initial $200, yearly $75. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (2) Bilingual for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500 - $4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave- 1½-days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (Qualified) for Victorian Order of Nurses (Toronto Branch). Minimum salary $3,600, consideration given to past experience. Annual increments, 5-day wk., 4-wk. vacation. $100 uniform allowance. P.S.I. & Supplementary Blue Cross available, pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto 2, Ontario. WA. 1-3184

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Nurses (Bilingual) having a public health certificate for a Health Unit in rural Ontario. Minimum salary $3,300, 5-day wk., cars available or allowance for own car. Cumulative sick leave. For further information write to: Dr. R. G. Grenon, Director, Prescott & Russell Health Unit, Hawkesbury, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Director of Nursing for modern non-profit, J.C.A.H. Accredited 125-bed General Hospital. Downriver area, Detroit, Michigan. $8,000 - $10,000 yearly, depending on qualifications. Liberal personnel policies, unusual opportunity. Approved residency program; staff, board certified specialists. Progressive expanding organization. Emphasis on postgraduate education. Experience in Nursing Service, Supervision & Administration preferred; Master's or Bachelor's Degree required. Forward complete details to Box K, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

VICTORIAN ORDER OF NURSES FOR CANADA . . .

requires

PUBLIC HEALTH NURSES

for Staff and Supervisory positions in various parts of Canada.

Applications will be considered from Registered Nurses without Public Health training but with University entrance qualifications.

SALARY, STATUS AND PROMOTIONS ARE DETERMINED IN RELATION TO THE QUALIFICATIONS OF THE APPLICANT.

Apply to:

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for Canada
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THE ROYAL ALEXANDRA HOSPITAL

EDMONTON, ALBERTA

Requires

General Duty Nurses for Medical, Surgical, Obstetrical and Pediatric Services and for the Operating Room.

Minimum salary $270 per mo. with Alberta Registration.

Good personnel policies.

Apply to:

**DIRECTOR OF NURSING,
ROYAL ALEXANDRA HOSPITAL,
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For

CRIPPLED CHILDREN

Requires Immediately

QUALIFIED EXPERIENCED PUBLIC HEALTH NURSES

YOU WILL RECEIVE —

- GOOD SALARY RANGE
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You will deal directly with children, their parents and service club members.

Join our expanding staff for a rewarding experience

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FOR CRIPPLED CHILDREN
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Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in the Montreal area). Excellent personnel policies, working conditions, and accommodation in the Nurses' Home. Apply to: Box 1000, Ste Agathe des Monts, Que.

SASKATCHEWAN

Matron & General Duty Registered Nurse (1) immediately for 22-bed modern hospital, close to lake, good fishing & golfing. Salary; Matron $350; Registered Nurse $280 per mo., 40-hr. wk., 4-wk. vacation with pay, modern residence, board & room $30 per mo., if desired. Apply to: Secretary Manager, Brock Union Hospital, Arcola, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses immediately (2) for 50-bed hospital. Salary $275 per mo., 40-hr. wk., no split shifts. $10 extra for night shift, comfortable residence. Good location with excellent bus & rail service. Apply to: Matron, Union Hospital, Rosetown, Saskatchewan.

U.S.A.

Supervisory or Staff Position; according to your qualifications. (Come to Sunny California). This 500-bed accredited teaching hospital offers unusual opportunities for growth. Excellent starting salary & increment program. Holidays — sick leave — vacations & Group Insurance. We feel sure we will be able to place you, we know you will like being associated with this modern progressive hospital that is located in the heart of the greater Los Angeles metropolitan area. Apply: Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn., O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered General Duty Nurses (2) for small General Hospital. Salary $375 per month. For information write: Box 336, Dos Palos, California or phone Express 2-3266 collect.

General Duty Nurses for large teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2 California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Duty Staff Nurses for 450-bed fully approved hospital. Salary range per month:- Day duty $404 - $423; P.M. & Night Duty $414 - $434; 40-hr. wk., excellent personnel policies. Registration or permit to work in California required. Address applications to: The Chief Nurse, Southern Pacific Hospital, San Francisco 17, California.

Operating Room Nurses: Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (1½) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

SOUTH PEEL HOSPITAL
COOKSVILLE, ONTARIO
(12 miles west of Toronto)

120-bed General Hospital, Opened May, 1958.

I. Evening Supervisor

II. Head Nurse with experience for Nursery (34-bassinettes)

Generous benefits, 40-hour work week.

For further particulars, apply:

DIRECTOR OF NURSING,
SOUTH PEEL HOSPITAL,
COOKSVILLE, ONTARIO.

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

REGISTERED NURSES

Small hospital in company operated town has vacancies for General Duty Nurses.

Ontario registration required.

Accommodation available in nurses' residence, community organized recreation, welfare benefits.

Salary range $306 - $397 monthly.

Apply to: Matron

SMOOTH ROCK FALLS HOSPITAL,
SMOOTH ROCK FALLS, ONTARIO

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Monthly salary rates: $370-$400 days; & $400-$430 afternoon & nights, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $450 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses for 278-bed fully accredited hospital with all services, incl. Starting salary $350-$375 per mo., ICU Retirement Plan, paid insurance, & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

Graduate Staff & Operating Room Nurses for 225-bed General Hospital, near New York City. Apply: Director of Nursing, St. John's Riverside Hospital, Yonkers, New York.

Operating Room Supervisor for 88-bed modern JCAH General Hospital. Minimum salary $335 based on qualifications, $40 call pay. Liberal personnel policies. College town 30,000, 85% sunshine belt, dry mild all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses (Intensive Care Unit) for real bedside nursing. Take advantage of this excellent opportunity to gain experience in the newest media of patient care. You will be trained at full salary to serve in St. Paul Hospital's second Intensive Care Unit. Openings for all shifts, excellent employee benefits. Inquire: Personnel Department, St. Paul Hospital, Dallas, Texas.

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years. Pension Fund.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 2; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN FUNDAMENTALS OF NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include: Clinical and classroom instruction in fundamentals of comprehensive patient care; integration of Introductory Pharmacology (solutions and dosage); instruction in an integrated course of Medical-Surgical Nursing.

Requirements: University preparation in Nursing Education.
Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING,
2240 KILDARE ROAD, WINDSOR, ONTARIO.

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

REGISTERED NURSES
NURSING ASSISTANTS

Required for all departments in new 160-bed hospital, centrally located between Toronto and Hamilton, in a very progressive community.

Good salary and personnel policies, pension plan, 40-hour week.

Apply stating age, qualifications to:

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CERTIFICATED PUBLIC HEALTH NURSE

with midwifery training and at least 5 years experience
for Community Development at University College
in Basutoland, part of which deals with Social Welfare.

For particulars and conditions of service, address applications to:

REVEREND FATHER GUILBEAULT, O.M.I.,
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Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

BRITISH COLUMBIA

Registered Nurse for new 26-bed hospital in the Fraser Canyon 100-mi. east of Vancouver, B.C. Basic salary $285 — shift differential, 40-hr. wk., 1-mo. annual vacation. Accommodation available in a new nurses' residence. Apply: Director of Nurses, Fraser Canyon Hospital, **Hope,** British Columbia.

SASKATCHEWAN

General Duty Nurse (1) for 25-bed hospital in a progressive area. New hospital of 34-beds is being planned. Salary range $290-$320 per mo. gross. 40-hr. wk. 3-wk. annual vacation, accumulative sick leave, new nurses' residence. Apply to: The Secretary Manager, Leader Union Hospital, Leader, Saskatchewan.

ONTARIO

Clinical (Teaching) Supervisor for Operating Room; postgraduate study essential; previous teaching experience desirable; duties to include staff orientation & in-service education; an interesting position for a progressive person; attractive personnel policies; salary in accordance with preparation & experience. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Head Nurse for Newborn Nursery in modern department; postgraduate experience desirable, but previous experience would be considered. Attractive personnel policies. Salary in accordance with qualifications. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses & Certified Nursing Assistants needed to open new 165-bed wing in a 350-bed General Hospital located in suburban Toronto. Good salary, personnel policies include 5-day work wk., 8 statutory holidays. R.N. vacation after 1-yr. - 3-wks. Cert. N.A. - 2-wks. Living-in accommodation. Apply to: Director of Nursing, General Hospital, Scarborough, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, hospital plan, hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½-days monthly, vacation 4-wks. a year, allowance for use of own car. Salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J. R. Mayers, M.O.H & Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

General Duty Nurse & Certified Nursing Assistants for 100-bed General Hospital attractive town in vacation resort area on Lake Huron. Good personnel policies, residence accommodation available. Apply to: Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital. Starting salary: $265 per mo. plus shift allowance. 40-hr. wk. 4 wk. vacation after 1 yr. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

QUEBEC

Registered Nurses needed for General Duty. Good personnel policies, including salary. Rotation. Hôpital de la Providence, Chandler, Cte. Gaspe, Quebec.

Registered Nurses (Immediately) for Operating Room & General Duty. Excellent working conditions. Write to: The Employment Office: **Hôpital Ste. Justine,** Chemin Ste-Catherine, Montreal, RE 1-4931, local 209.

Registered Nurses for General Duty at company hospital in Temiskaming, Quebec. Salary scale in effect providing generous periodic increases, based on merit & service. 40-hr. wk., 4-wk. annual paid vacation. Attractive community life with variety of winter & summer recreational activities. Bus & rail connections to all major points. Apply in writing to: Mrs. M. Walden, Canadian International Paper Company, Room 942, Sun Life Building, Montreal, Quebec.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

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FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80) bi-weekly until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

REGISTERED NURSE

(PUBLIC HEALTH TRAINING)

An opening at the Bluebell Mine of The Consolidated Mining and Smelting Company of Canada Limited, situated on beautiful Kootenay Lake at Riondel, near Nelson, B.C.

Duties include nursing services for employees, their families and the community, acting as intermediary between patients and non-resident doctors. Home visits to sick or injured. Arranging for and assisting doctor in weekly clinics. Cooperate with First Aid Group, providing nursing service to accident cases on property. Other related duties. Emergency hospital at property.

Accommodation available with modern conveniences.

Starting salary: $365 per month.

Apply Supervisor, Staff and Training Department, Personnel Division

THE CONSOLIDATED MINING AND SMELTING COMPANY OF CANADA LIMITED, TRAIL, B.C.

2 INSTRUCTORS

Certificate
in Nursing Education required

One to teach basic Science

Student enrollment 70 - 80

One class per year
registers in September

Well equipped modern School
& Residence

ASSISTANT DIRECTOR NURSING SERVICE

Evening or Night Period

Previous supervisory experience required. Certificate in Nursing Service Administration desirable.

200-bed hospital - fully accredited. Pleasant city 38,000 close to larger centres. Good salary & personnel policies. Additional salary for advanced preparation above positions.

For further details apply to:

**THE DIRECTOR OF NURSING
GENERAL HOSPITAL
GUELPH, ONTARIO**

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

**DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.**

STAFF NURSES

430-bed General Hospital, JCHA accreditated. All clinical areas. Salary $320. to $400. per month days; $340. to $420. per month evenings and nights; automatic annual increases; credit given for previous experience. 40-hour, 5-day week; paid overtime, holidays, vacation and sick leave. Excellent opportunities for promotion. Active orientation and in-service education program. Living quarters available if desired.

Write to: Director of Nursing,

THE CHARLES T. MILLER HOSPITAL, ST. PAUL 2, MINNESOTA

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

CALIFORNIA

REGISTERED NURSES

(General Duty with opportunity for advancement)

New modern 130-bed General Hospital in dynamic college city in beautiful San Joaquin Valley only 2 hours from Los Angeles

Only evening & night positions open
Starting salary $350 per mo.
5-day, 40-hr. work wk. Progressive personnel policies.
Transportation cost to California will be reimbursed after 2-yr. satisfactory service.

Send full particulars immediately to:

DIRECTOR OF NURSING SERVICE, GREATER BAKERSFIELD MEMORIAL HOSPITAL
P.O. BOX 26, BAKERSFIELD, CALIFORNIA

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Residence accommodation available.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
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DIRECTOR OF NURSING

General Hospital of 109 beds, located in Northwestern B.C. requires Director of Nursing.

Salary is open and dependent on qualifications and experience. Residence accommodation available if desired.

Apply giving full particulars of education and experience to:

ADMINISTRATOR, PRINCE RUPERT GENERAL HOSPITAL,
PRINCE RUPERT, B.C.

THE OTTAWA CIVIC HOSPITAL

WITH

A capacity of 1200 beds including
A new modern 300 bed unit

OFFERS

An interesting variety of experiences
Good personnel policies
Salary allowance for experience and postgraduate courses.

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DIRECTOR OF NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

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REQUIRED FOR

Approved School of Nursing with new
125-bed Residence & School
Accredited Hospital — 300-beds
on or before August 1st.

Apply: Director of Nursing,

ST. THOMAS-ELGIN GENERAL HOSPITAL,
ST. THOMAS, ONTARIO.

PUBLIC GENERAL HOSPITAL
CHATHAM, ONTARIO

requires an
INSTRUCTOR
for
NURSING SCHOOL IN
A 300-BED HOSPITAL

For further information apply to:

DIRECTOR OF NURSING,
PUBLIC GENERAL HOSPITAL,
CHATHAM, ONTARIO.

INSTRUCTORS

required for

school of 75 students
in modern 157-bed hospital
with expansion program.

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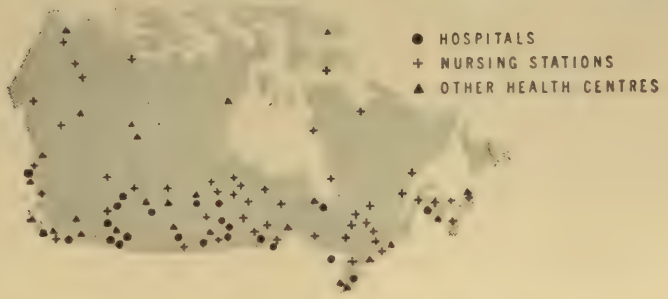
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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief, Personnel Division,

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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
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Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
In combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four week's notice and the *old* address as well as the new are necessary.
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Between Ourselves

Journeying across the province of Saskatchewan in the dome of the *Canadian* or motoring along the TransCanada highway, a traveler is aware of the treeless expanse of flat prairie, dotted here and there by tiny ponds that reflect the very blue sky above. The horizon stretches away for fifty miles, at least, in every direction. Depending on the season, the fields will be green, golden or snow covered. This is the bread basket of Canada for Saskatchewan ranks first among the provinces in the production of wheat, oats and flax.

The traveler who ventures away from the southern routes will find a different landscape. The countryside north and east of Prince Albert is heavily timbered with tamarack, spruce and jack pine. Gently rolling hills and broad fertile valleys present a more familiar landscape to those from other parts of our country. There, in the little town of Speers, not far from North Battleford, our guest editor, ELEANORE LOUISE MINER, was born. Though she went to Royal Alexandra Hospital in Edmonton for her nursing education and roved farther afield in her early professional practice, since 1945 Miss Miner has engaged in public health nursing in her native province. She is presently one of the consultants with the Provincial Department of Health.

The Saskatchewan Registered Nurses' Association is justly proud of the splendid new building that is now its home in Regina. President of the SRNA since May, 1959, Miss Miner was chairman of the Building Committee during the very busy days of planning and construction.

* * *

Three of the articles that won prizes in this year's Macmillan Award competition are included in this issue. Nurses in Edmonton, Alberta, may take special pride in the fact that all three of these student authors are receiving their education in schools of nursing in that city. We congratulate these youngsters and wish them well in their chosen profession.

Three other comprehensive nursing care studies that were also awarded prizes will be published in subsequent issues.

* * *

Most human beings treasure the hope that their advancing years may be spent in happiness and contentment. To achieve this goal they need only two things — economic security and freedom to do as they please. Yet, how many old people are acutely discontented and unhappy because well-meaning relatives and friends try to "take charge of them"? They may reach a state of boredom when neither medical science nor good nursing care can be of assistance. It is important, therefore, that every nurse should know not only how to care for the aged when they are ill but also be aware of this basic concept of geriatrics: *old age can be satisfying*. It need not, should not, be simply a period of idly sitting and waiting for the inevitable death.

We were delighted recently by a glimpse of an old lady of 94, who, spry as a cricket, was standing on a ladder making some necessary repairs to a rose trellis. Her daughter, aged 72, was not sure-footed enough to climb the ladder so she was busy trimming the borders of the flower beds.

Volumes have been written on gerontology. The series of articles included in this issue can touch on only a tiny sector of this topic. The nurse who takes the trouble to know her aged patients as the individuals they are may often benefit from a philosophy of life that only the passing of years can bestow.

* * *

Some months ago we stated in the *Journal* that the mouth-to-mouth method of artificial respiration had not yet been approved as a useful technique by the Canadian Red Cross Society. Believing that there are frequent occasions when it is particularly effective, we are pleased to note that the central council of the Society has recently adopted a resolution to include this method in the instruction given to their first aid classes.

* * *

It has been our custom to include our day-by-day report of the biennial meetings of the Canadian Nurses' Association in the August issue of *The Canadian Nurse*. To meet our deadline dates, it has been necessary to postpone the publication of the story until the September issue. Watch for it then.

An awareness of team nursing is not confined to the nursing staff of the Montreal Children's Hospital. Recently a very young patient asked the nurse, "Am I on your team?" Following a positive reply, he queried further, "Who's winning?"



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Manufacturer—Mead Johnson of Canada Ltd., Belleville, Ontario.

FULVICIN

Indications—An antifungal antibiotic orally effective against ringworm of the scalp, beard, body, hands, feet, fingernails and toenails.

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Administration—Children: 10 to 25 pounds, 5 mg. per pound of body weight q.6 h.; 25 to 50 pounds, 1 teaspoonful q.6 h.; over 50 pounds, 2 teaspoonfuls q.6 h. Adults: 2 teaspoonfuls q.6 h. In more severe infections, these dosages may be doubled.

Manufacturer—Eli Lilly and Company (Canada) Limited, P.O. Box 4037, Terminal "A," Toronto 1.

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Administration—Usual dosage: children: 10 to 25 pounds, ½ teaspoonful q.6 h.; 25 to 50 pounds, 1 teaspoonful q.6 h.; over 50 pounds, 2 teaspoonfuls q.6 h. Adults: 2 teaspoonfuls q.6 h.

Manufacturer—Eli Lilly and Company (Canada) Limited, P.O. Box 4037, Terminal "A," Toronto 1.

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Random Comments

Dear Editor:

I would like to take this opportunity to thank you for such an excellent magazine. As I am no longer active in nursing, it gives me a very good opportunity to keep up with the new trends. I especially enjoyed the mental health series, and the nursing care studies are most interesting.

M. E. M., Ontario

Dear Editor:

Please accept my congratulations for the work you are doing in producing a magazine of the quality of our *Canadian Nurse.*

A. H. M., Nova Scotia

Dear Editor:

I enjoy reading the *Journal.* Sometime in the future would you please feature "Intensive Care Unit." It is an apparently very new way of providing specialized care to very ill patients. Patients would have to rely less on private duty nurses. It is separate and apart from the postoperative recovery room.

If some, who have experienced this new setup, would write about it and share it with the rest of us, it would be appreciated.

B. J. F., New Brunswick

¶*A request has been made to have the supervisor of such a unit prepare an article on this subject. It will appear in a future issue of the Journal.* Ed.

Dear Editor:

I am writing to thank you for the article "The Greatest of These" which appeared in the March issue of *The Canadian Nurse.*

I am an older nurse, trained in the 1920's, but working in an active labor and delivery room. I still believe we are there to look after the patient and that is our primary purpose. When we went in training our ambition was to nurse sick people not write reams of paper.

Thank you again. We need a few more articles like it and put them in a prominent place.

D. S., Ontario

¶*This article was originally published in R.N. and reprinted in the ICN Review.* Ed.

Dear Editor:

I often think of Canada and the University of Toronto from which I graduated in

1930. Montreal, too, brings back memories of the ICN congress held there in 1929. The city was so beautiful.

I am so grateful to a Canadian nurse for sending me a copy of the *Canadian Nurse*. I wish I could pay for it but I cannot have Canadian money.

I am working in the largest hospital in Korea. It is a combined project of the Scandinavian and Korean governments with the aid of UNKRA. It has a three-year school of nursing with entrance requirements and standards very similar to those of Canadian schools.

My best wishes to the *Journal* and the Canadian Nurses' Association.

FRANCES L. WHANG
Seoul, Korea

MEMORIAL BURSARY

St. John Ambulance recently announced the establishment of a bursary fund in memory of the late Countess Mountbatten of Burma, Superintendent-in-Chief of the St. John Ambulance Brigade in the Commonwealth and Vice-President of the Royal College of Nursing. This fund is to be used as bursary assistance in nursing. The first award will be available in September, 1960. At the outset, first consideration will be given to an applicant identified with the St. John Ambulance.

For details apply to the Chairman, The Countess Mountbatten Bursary Fund, St. John Ambulance Headquarters, 321 Chapel Street, Ottawa 2, Canada.

* * *

£1,000 has been donated by the Royal College of Nursing in Great Britain to assist in the organization of nurses for relief work being undertaken by the British Red Cross Society, in the recently devastated areas of Mauritius and Morocco.

The money comes from a special fund, held by the Royal College of Nursing, for organizing trained nurses to assist in relief work abroad.

* * *

We have a comparatively decent system of common schools, schools for children only, but no schools for ourselves. It is time that we had uncommon schools, that we did not leave off our education when we begin to be men and women.

— HENRY THOREAU, 1854

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---

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---

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 7

MONTREAL, JULY 1960

VIGOROUS GROWTH

THE SASKATCHEWAN Graduate Nurses' Association was formed in 1911. On April 24, 1917, forty-three years ago, the first recorded meeting of the Saskatchewan Registered Nurses' Association was held, with Miss Jean Browne as president and Miss Jean S. Wilson as secretary. The full council, named later in the year, was comprised of six nurses and two physicians.

Office space was located "under the bed" of the voluntary secretary-registrar, to accommodate files of the 99 members. The first convention of the SRNA was held in 1918 in accordance with the Act respecting the Association that was passed in 1917. Saskatchewan was the second province to pass such an Act. The first annual meeting recorded a resolution favoring "the support of nursing as a permanently important and satisfying profession."

Devoted nurses worked hard to foster the growth of the Association. A part-time secretary-treasurer was employed in 1920 and by 1922 office space was provided by the Red Cross Society in Regina. The office was later housed in the Institute for the Blind in Regina, and by 1925, 168 members were financing a $10.00 monthly rental. Records show that office quarters were moved three more times in Regina before being transferred to the University of Saskatchewan in Saskatoon in 1938. Miss Kathleen W. Ellis became



(West's Studio)

LOUISE MINER

part-time secretary-treasurer-registrar in 1937 and was active in that position until 1950.

A travelling instructor was appointed in 1943. This position, now that of adviser to schools of nursing, has recently been part-time. Ways and means are under study to make this a full-time position again.

The first assistant registrar was appointed in 1947. Membership had increased to 2160 in 1950. At that time Miss Lola Wilson was appointed the first full-time secretary-treasurer-registrar. She took the title of executive secretary-treasurer in 1956 when Miss Grace Motta was appointed the first full-time registrar.

The office was moved back to Regina in 1950; floor space was increased in 1952 and again in 1956.

The SRNA Act was amended in 1955 to include nursing assistants and provision was made for their certification in 1957. The organization meeting of the Saskatchewan Nursing Assistants' Association was held in 1958.

The work of the executive-secretary, registrar and four member office staff and of Council continued to increase. By 1959 registered nurses' membership numbered 3738 and certified nursing assistants 510.

The finances of the SRNA had been in capable hands. More recent members owe a great deal to former members, who are largely responsible for the favorable bank balance that allowed for consideration of the construction of an office building for the Association.

The May, 1958 annual meeting passed the motion that "the council be empowered to proceed with the selection of a suitable building for the SRNA headquarters and that they appoint a Building Committee which would advise and help in this project." A twelve-member committee was formed and began work immediately. A concerted six-week effort followed, contacting all real estate companies in Regina, making over a hundred telephone calls and assessing 20 sites before papers were signed for the purchase of a 65′ x 125′ lot and a two-storey frame house at 2066 Retallack Street. The house was sold and moved. During the 18 months following the decision to build, nine meetings of the full committee and numerous subcommittee meetings were held before the offices of the SRNA, after 43 years of wandering, found their own home on November 26, 1959.

"Home" is a two-storey building with full basement 52′ x 40′ in size. The front is of buff brick with the sides and back of concrete block in a matching color. An additional storey may be added if necessary and facilities are provided to allow for the installa-



S.R.N.A. Building

tion of air conditioning at a later date, if required. An "intercom" system connects the front office with two private offices and the conference room. The main flooring is of tan vinyl tile.

The building faces east. On entering, you find a beautiful SRNA crest in gold, maroon and white in the centre of the tan-colored terazzo floor (courtesy of Antonini and Sons who laid the flooring). One buff brick waiting room wall has a brass wall-clock. Facing you is a mahogany wall, an attractive planter lighted by hanging brass light fixtures, and a green stair-well with terazzo stairs. Pretty moss green upholstered mahogany furnishings make this one of our favorite corners. To the right is a sunshine yellow general office with a pumpkin-color topped mahogany reception counter and additional work counter space under the west window. A mimeograph room in green and cocoa, and a vault, open off the general office. A folding mahogany door permits the locking of the entire office area. Private offices face east, two in yellow and two in green with walnut office furnishings.

Sliding doors are used in the hall bookcase, private offices, lounge, kitchen and locker room to conserve floor space.

The conference room and lounge on the second floor have an east wall in blue with attractive interlined drapes that will be useful for film projection. Two walls of the conference room are in beautiful walnut panelling with central folding areas covering chalk boards. The two doors to the conference room are also in walnut. One folding walnut door separates the conference room from the lounge and another will divide the conference room. Brown, turquoise and gold upholstered walnut lounge furniture, walnut tables and podium, and tan Fiberglas stack chairs furnish these rooms. A small blush-colored kitchen with double sink, stove and refrigerator adjoins the conference room and lounge. The locker room is painted cream, the cloak area is a blush shade, and the washrooms are a moss green with pumpkin-colored counter tops. Adjustable steel shelves provide for basement storage. An adequate parking area is hard-surfaced.



S.R.N.A. Waiting Room

Growth and development — from office space under a bed to a $100,000 investment of building and property, entirely paid for by a beginning nurse membership of 99, reduced to 41 in 1922, then steadily increased to the present figure. Twelve chapters of registered nurses and four of nursing assistants are now active in the province.

Saskatchewan registered nurses are proud of their heritage and humble in the knowledge of the debt they owe the pioneers and the long standing members of their Association. To whom much has been given — from them more shall be expected. Our building accommodated 44 meetings in the first three months of this year. Tribute is due present and past executive secretaries, registrars and office staffs. Association members sincerely hope that our office building may be wisely and effectively used, in keeping with the resolution of its first annual convention: "in the support of nursing as a permanently important and satisfying profession."

Louise Miner,
President,
Saskatchewan Registered Nurses' Association

A survey of 127 companies revealed that 69% employed known diabetics. Regarding the companies' "experience as to reliability and absenteeism," 51% felt it to be satisfactory and 47% claimed it to be "same as average worker." — *Occupational Health Bulletin*

Mental Diseases of Old Age

JOHN GIBSON, M.B., CH.B., D.P.M.

One of the very disturbing aspects in the care of the elderly may be their tendency to undergo regressive personality changes. It is very hard for the family to watch an alert, intelligent, independent member become forgetful, disoriented, incoherent, irritable and unhappy. Why do such changes occur? What are the chances for control or cure?

THE COMMONEST mental diseases of old age are senile dementia, arteriosclerotic dementia, depressive and manic illnesses, paranoid states, and confusional states.

Senile Dementia

Senile dementia does not usually begin before the age of 60. More women are affected than men. The brain shows atrophy and a generalized disappearance of brain cells. The cause of this change is unknown but hereditary factors probably play a part in its production.

Common symptoms are: a decline in intelligence, emotional disturbances and apathy, proceeding to a severe disorganization of the personality. The earliest symptom is a loss of memory for recent events, while memory for remote events, such as those of childhood, may remain good. The common emotional expressions are irritability and peevishness. Paranoid delusions are likely to develop and the patient may make accusations of theft and poisoning. Insomnia and restlessness are common. The patient wanders about, gets up in the middle of the night, shouts out of the windows, turns on gas taps, wanders into the street. Control of the sphincters is lost early. Speech is wandering and irrelevant and degenerates to a babble of meaningless sounds. Once begun the disease progresses to profound dementia. A fracture or acute physical illness may precipitate an acute confusional attack. Admission into hospital often produces rapid deterioration; about half the patients admitted die within six months.

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the eighth of a series of articles on psychiatric subjects.

Arteriosclerotic Dementia

This is due to cerebral arteriosclerosis either alone or associated with hypertension, the clinical picture of the two conditions being slightly different. More men are affected than women, and the illness begins at an earlier age than senile dementia.

Cerebral arteriosclerosis produces an impairment of memory for recent events, a reduction of intelligence and ability, a narrowing of interests, and an inability to grasp new situations. Unlike senile dementia this condition produces little change at first in the personality of the patient, who may be aware of his deterioration and respond to it with anxiety and depression. Parkinsonism and epileptic attacks that may be major, minor or Jacksonian in nature, may occur. Hypertensive patients are likely to suffer headaches, giddiness, unsteadiness and blackouts. Insomnia and nightmares produce restlessness and anxiety. The patient becomes irritable and unhappy, and is apt to vent his unhappiness on others. Acute confusional states, lasting from a few hours to a few days, in which the patient is confused, disoriented, deluded and hallucinated may occur. He may die in such an attack or survive to suffer more. Attacks of hypertensive encephalopathy may occur. These produce a sharp rise in blood pressure, vomiting, blindness, epileptic attacks and paralysis. The attacks last for several hours and leave the patient partially paralyzed. With each exacerbation of the illness deterioration takes place, until pneumonia, heart failure or a cerebral hemorrhage closes the scene.

The treatment of the hypertensive patient is essentially medical, with appropriate drugs and a readjustment of his way of life to his disability.

With the development of severe mental changes, admission into a mental hospital becomes necessary.

Depressive and Manic Illnesses

These may occur in the elderly as in younger people. Some have their first attack after the age of 60. Attacks of depression are much commoner than attacks of mania. They may appear as typical attacks of the manic-depressive variety, with depression and retardation as predominating features. They may take the form of an involutional melancholia, with depression, anxiety, agitation, paranoid ideas, and nihilistic delusions. They may appear as a "neurosis," with anxiety, insomnia, and preoccupation with bodily functions, such as the state of the bowels. Depression in old age may be precipitated by retirement, bereavement, poverty and loneliness. Suicide is common.

Attacks of mania are very similar to those of earlier life, with a sudden onset — flight of ideas, delusions of wealth and physical or sexual prowess — and often a sudden termination. In some the mania continues as a chronic state.

The prognosis for the majority of these attacks is good. Treatment follows the usual lines for depressive and manic illnesses. Old age is not *per se* a bar to ECT.

Paranoid States

Paranoid states developing for the first time in old people are more common in women than men. They are often associated with some degree of blindness or deafness. The condition closely resembles paraphrenia of middle age. Typical delusions are those of persecution. The patient believes that he is being poisoned, that he is being subjected to rays projected on to him by police or malign neighbors, that slanderous reports are being circulated about him by word of mouth or in the newspapers. He is likely to be noisy, abusive and threatening, or may barricade himself in his room. He is completely without insight. He retains his personality, habits and appearance in all matters not affected by his delusional ideas. Admission to a mental hospital becomes necessary when his behavior becomes abnormal. He regards this as part of the plot against him. The patient usually remains deluded for the rest of his life.

Confusional States

Such acute states are common in old age. They may be precipitated by organic disease of the brain, such as cerebral arteriosclerosis and cerebral tumor; by pneumonia, acute bronchitis, or other infection; by heart failure; by surgical operations, especially prostatectomy and removal of cataracts. They may be associated with gross vitamin deficiency in the diet, especially when an old man lives alone in poverty. During an attack the patient is restless, confused, disoriented, hallucinated. He does not sleep, takes little or no food, and may become dehydrated. The death rate is high, but recovery is possible. A few patients are left demented. Treatment is admission to hospital, the administration of food and drink (tube feeding is usually necessary), the provision of an adequate vitamin intake and sedation for which paraldehyde is the safest drug.

Rest and inactivity, once a cardiac lesion has healed, do not prolong life . . . Too much rest is likely to lead to physical and emotional incapacity. These statements were made in *Circulation,* journal of the American Heart Association, by three leading authorities on the care of cardiacs. They suggest that "we must accept the philosophy that work is a normal part of living and important for the physical and emotional well-being of the individual."

Social influences that may hinder recovery such as an over-protective wife or children, advice from well-meaning but uninformed friends, and too restrictive medical counsel tend to emphasize the gravity of the ailment and add to the disability.

The return of heart patients to work is also important to the national well-being. Unless these people can support themselves they will be dependent on their families and governmental aid and will pose a staggering economic burden.

—American Heart Association, *Newsletter*

Geriatric Nursing in the Home

LORRAINE F. MILLER

There is an increasing demand for visiting nurse service to the elderly in their own homes. With the help and support of nurses and the patients' relatives old folk can live out their last years in happiness in the security of family life.

TWO THOUSAND YEARS ago the average life expectancy was 20 years. In 1900 it was 49 years — today it is 70 years. An increasingly large number of Canadians are living longer than 70 years as the following comparisons shows.

Percentage of Total Population for Different Ages.

	1956		1958 (estimate — June 1)	
	65+	70+	65+	70+
Nfld.	6	3.8	6.5	3.6
P.E.I.	10.4	7	10.7	7.3
N.S.	8.5	5.6	8.8	5.6
N.B.	7.8	5	8	5.3
Que.	5.7	3.4	5.6	3.5
Ont.	8.5	5.3	8.1	5.1
Man.	9	5.6	9	5.8
Sask.	8.9	5.5	8.9	5.8
Alta.	7.3	4.4	7.1	4.5
B.C.	10.9	6.9	10.2	6.8
Y.T.	4	2.5	3.1	1.5
NW.T.	2	1.5	2.5	1.5
Canada	7.7	4.2	7.5	4.8

Canada Year Book, 1959

In the two-year interval the over 70 population increased in six provinces, with a national average of 0.6 per cent. In 1956 the population of Canada totalled 16,080,791 of which 1,243,938 were 65 and over and 779,825, 70 years and over. In the next two years the population increased by 967,207 — the number over 65 was larger by 41,462 and the number over 70 by 42,475.

Meeting the problems of an aging population is a major task. What can be done to make "the last of life the best?" Too many of our senior citizens are not enjoying these latter years. They are often the tragic products of a society that has lengthened their life span without planning and providing for the consequences.

In a study of 95 individuals (36 hemiplegics) who were being given custodial care as "chronics," only seven were considered to be actually in need of continued institutionalization. Many studies have been made to determine the advantages of home care for the older patient. It is estimated that 92 per cent of patients with hemiplegia can be taught selfcare in six to eight weeks. Many of our so-called chronics are not so "chronic" when they are encouraged to function actively in a family setting.

There are difficulties to overcome in any plan of home care and there *must* be a plan. Personality patterns of both patient and family are affected by long-term illness. In wholesome, happy, well-adjusted families the adaptation and adjustment can usually be made

Miss Miller is director of the Saskatoon Branch of the Victorian Order of Nurses. This material was presented at a Saskatoon Chapter, S.R.N.A., refresher course.

easily in an atmosphere of love and cooperation.

Some of the Problems

Elderly folk, like younger ones, vary greatly. Many at an advanced chronological age are mentally clear and alert, enjoying life. Others who are much younger may require full care. In between is a large group who need some assistance and supervision.

The elderly person for whom a program of care is being developed should be asked to take part in the planning. Parents and grandparents who have accepted responsibility for years and managed adequately should not be suddenly asked to accept changes and plans that others have made for them. They appreciate consideration and, whenever feasible, their advice and reaction toward impending changes should be considered and accepted.

Loneliness is a great problem for the elderly. Their contemporaries may have died, moved away or become unable to get about. The loss of husband or wife leaves the partner lonely and often without an incentive to go on living. Families may contribute to loneliness by moving the elderly person to be near them, but away from friends of their own age group. The family have usually adjusted by this time, but the older person has to adjust to extreme changes at a time in his life when it is not easy. Frequently, elderly couples move to a city where they find life easier but more expensive. Their means are usually limited, so they tend to economize on food. Loneliness coupled with such economy can lead to illness.

To those who have always been active, inactivity causes unhappiness. Sudden lack of something to do results in apathetic listlessness. Grandparents can be asked to help with the housework, handiwork, odd jobs. The home offers many opportunities for activity. Families must accept the fact that most elderly people are happier and healthier when they are encouraged to help and have regular tasks to do.

The Patient and the Family

The family may present a greater problem than the patient. One must always be sure that they can fulfil the responsibilities left with them. Plans for care must be made with consideration for the abilities and emotional involvement of the family members. They are on duty 24 hours a day.

The chronically ill patient, especially those with arthritis, are always hopeful of an elusive "cure." It is important for the family to follow the advice of the physician and not be influenced by well-meant advice from friends and neighbors. The family needs to understand that attaining goals of rehabilitation takes time.

Every patient and his family experience emotional reactions. The elderly must adjust to the frustrations of limited activity; the family must adjust to the loss of a guiding influence, or to the care of a bedfast individual or one who is mentally incompetent. To achieve a happy medium of support and encouragement is all important — doing neither *too much* nor *too little*. Both the nurse and the family must recognize that an uncooperative, ill-tempered patient may be expressing his rebellion and insecurity.

Senile patients may be very difficult to care for at home, but they often die very soon after they are removed from the security that the home affords. The family who keeps a senile oldster at home needs a great deal of help and encouragement. Some days will be good, others very bad. It requires infinite patience and love to meet the demands for care under such circumstances.

Frequently, elderly patients have been active church members. Their spiritual needs remain the same. If attendance at church is not possible, they welcome visits from the clergy. The nurse can often help the family to arrange for such visits or for transportation to religious services.

The need for a break in routine for the family is all-important. "Senior sitters" or a temporary admission to a nursing home may be arranged. Both sides benefit from a "vacation" of this kind.

Physical Care

The program of nursing care aims at providing *active* care. The emphasis is on rehabilitation to whatever level is achievable.

In order to prevent deformities, decubitus ulcers, and other complica-

tions a program of physical care is important. Special skin care is essential for those who are confined to bed. Baths should be spaced, according to individual needs, since frequent bathing may cause dry, scaly skin. The back and other pressure areas require stimulation by friction. A cream-type lotion is better than an astringent such as alcohol. The use of foam rubber pads relieves and equalizes pressure. These must be kept clean and dry. Beds need firm mattresses. Fracture boards help to prevent "hollows." Proper positioning may be achieved by the use of pillows, trochanter rolls, etc.

Activity in bed should be started as soon as the physician permits. Self-help measures and active or passive exercises are recommended, progressing in complexity as the patient's condition improves. When skin care is being carried out, the nurse has an opportunity to teach full range of motion exercises. When the patient can sit up, active rather than passive exercise is encouraged. The aim is to secure the earliest possible ambulation.

> Recently, we were asked to visit a patient who had been in hospital for a full year. Quite literally, he was a "board." The doctor's orders specified that he was to be up. Some weeks and much effort, later, he could bend both knees and had considerable arm and hip movement. He was exercising energetically and expected to be walking "come fall." He was then 87 years of age.

Whenever possible tub baths should be given. A patient can go to the bathroom on crutches or in a wheelchair. To get into the tub the person can be seated on a chair beside it then swivelled around and her feet placed in the tub. Finally she is assisted onto the side and lowered gently into the water. Reverse the process to help her come out. A non-skid bath mat is a must. A firm bar, securely screwed to the wall, can be placed conveniently to assist in getting into or out of the tub. Patients can sit on a chair or a stool under the shower as an alternative. Precautions must be taken against the patient turning on the hot water tap too forcefully.

Individual needs and home resources provide the basis for an individual plan of care.

Sleep

A common problem is presented by the patient who sleeps most of the day and keeps his family up all night. Activity during the day and a hot toddy or hot milk at bedtime can work wonders. The family can help if they accept the fact that an occasional late night is good. If grandfather enjoys T.V. and being in the family circle, he will sleep better after an interesting evening. Elderly people often require as little as five or six hours of sleep.

Having a night light in the room, with familiar objects near at hand and visible, often helps to prevent the temporary confusion that elderly people may display at night. Make sure that the patient is comfortable, warm enough and that the bed clothes are not too heavy.

If a patient is sleepless we should be alert to the possibility of congestive heart failure. Breathlessness at night can be very disturbing. Urinary frequency, another cause of restlessness, may be indicative of urinary infection. Family members must be aware of such symptoms and report them promptly to the nurse or doctor.

Diet

Elderly patients require teaching and encouragement regarding adequate nutrition. Those who are active physically manage very well and seem to have few problems.

> There are three wheelchair patients known to our branch who do all their own housework and cooking. Their homes are spotless. The one thing they need is some gadget with which to pick things up — one patient uses a pair of long tongs. Another lady uses her oven for storage of articles that might be hard to reach. She also uses a small, low refrigerator instead of the larger, higher models and her milkman, breadman and postman all come into the house to make their deliveries. The extra time they spend does not seem to be a problem to them.

The elderly patient who is confined to bed presents a different picture. She tends to eat bread and milk or tea and toast, getting very little of the protein that she needs. Ground meat, homemade soup with meat and vegetables, stews, and baby foods may tempt the very poor eaters. Small meals taken

frequently and hot milk at bedtime may also be helpful in ensuring adequate nutrition.

For those who have difficulty eating, a plastic apron with a bib, helps to keep them tidy. A soup plate with deep sides keeps food in one place. The patient's "feelings" should be considered. One with Parkinson's disease or hemiplegia may reject company because he thinks he is objectionable to others.

Many patients "overdose" themselves with laxatives. A commode chair near the bed reduces the accident hazard. A regular time for evacuation can increase regularity and cut down on accidents.

Suggestions for Care

1. In homes with stairs a folding gate at the top is a guard against falls.
2. A railing along the wall of the staircase will help in steadying uncertain feet.
3. Avoid loose mats, rugs and highly polished floors.
4. Canes and crutches should have non-skid tips. Shoes should be well-fitted and have non-skid soles.
5. A rolling-pin and a pulley arrangement are good substitutes for more elaborate forms of exercise equipment.
6. A chair may be used as a walking aid.
7. A good bed and a firm mattress help to maintain good posture.
8. Safe placement of furniture will prevent accidents.

The Hemiplegic Patient

Perhaps the most challenging patient in the senescent group is the hemiplegic. Too often we see sad results when patients who have had a "stroke" are left to "vegetate." Yet it has been found that 92 per cent can be rehabilitated to good levels of self-care and even to earning a livelihood. The ingredients for success are time, patience, the right kind of philosophy, cooperation and encouragement. Once started on the road it is wonderful to observe what these patients can and will accomplish. They must believe in themselves and in their ultimate success.

We have seen "impossible" miracles happen in our modern world and if we practise believing, it is amazing what we can achieve. By looking forward with those who are now aged and helping them, we are helping ourselves to look to the future when we can say with the poet:

Grow old along with me,
The best is yet to be,
The last of life
For which the first was made.

—Robert Browning

IN THE GOOD OLD DAYS

(The Canadian Nurse — July, 1920)

Does our country need all of its population, or can we afford to allow thousands of our best people to die every year for want of care? Or I can bring the question closer to our hearts by asking: Do our individual homes need every member of the family, or can we easily part with one or more of the familiar faces? — Agnes Joynes, R.N.

* * *

The money value of a man includes the cost of his upkeep and education from his birth till he becomes self-supporting. He then becomes an asset instead of a liability.

This demonstrates the economic loss to the community when, through an accident, he is incapacitated and unable to carry on his work. All the cost of bringing him to the learning stage is wasted, and he again becomes a burden on society.

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Conservation of Nursing Resources

In view of the shortage of nurses, it was highly important to use the available ones where they were most needed. At the very beginning of the influenza outbreak, the Central Registry of Graduate Nurses had a long list of unanswered calls. At the same time it was known that many wealthy patients had two or three special nurses, who could get along with only one or none at all. Repeated appeals were made through the press for self-denial in the matter of nursing service in order that really urgent cases might be cared for.

Life in an Old People's Home

Myrtle Brodsky

For some time now there has been intelligent searching and honest concern about what happens to people after they retire. This author gives some answers about those who retire into a home for the aged.

Five years ago a new home for the aged was built in our community. Enthusiasm about it was high since it was felt that such a home would fulfil a need hitherto not met by any existing institution.

The ideal location for the home, or so it seemed to those responsible for planning, was just outside the city limits. The residents would be able to enjoy an open view of lovely countryside. The physical structure of the building provided for every comfort. An excellent heating system and air conditioning made for pleasant indoor living in winter's cold or the oppressive summer heat.

Married couples could live in apartments which provided the privacy of their own living room, bedroom and bathroom. At meal time they would meet with other residents in the communal dining room.

For residents who became ill and required bedside nursing care, an infirmary was available. For those who might show extreme mental confusion, facilities for segregation were provided so that other guests would not be upset.

To all outward appearances the home was everything that any community could desire for its elderly citizens. In actual practice how has it measured up? What is the effect of the environment upon the residents?

One of the most obvious effects has been an apparent obsession with health. The attending doctor's frequent visits and the constant presence of a nursing staff unavoidably tends to create an environment that is associated with illness. The result has been a heightened awareness of ills — real or imaginary. This is an unfortunate situation but since nursing care and medical supervision are required by many of the old people, it is a difficult feature to alter.

The doctor's visit is the great event of the day. He is watched for by many eager eyes. His arrival is a break in the monotony of communal living and an opportunity for pouring out their woes. The house doctor becomes accustomed to listening, is familiar with each person and his or her troubles, but a visiting doctor may find himself "taken in" with rather amusing results.

> One young doctor omitted to ask a patient how long she had been a sufferer from her particular symptoms. He ordered a course of treatment that he hoped would be a cure. When he finally discovered that she had had the condition for the past 30 years, with occasional flare-ups, he retreated to the aspirin plus hot water bottle type of therapy, slightly chagrined!

Medications are given out four times a day and the arrival of the medicine wagon in the lounge is an important event. It punctuates the routine of the patients' lives but it also provides an opportunity to procure that little extra attention that the elderly crave. Residents who have been up and about, suddenly find that weakness and exhaustion make it imperative for them to lie down on their beds and have their medications brought to them. Some complain to the doctor that they are receiving no benefit from his prescription, or that the quantity should be increased. But on enquiry, the doctor may discover that the medications have been refused or taken only intermittently. A certain amount of rivalry may develop in this bid for attention. Individuals who are really in very good health may be influenced by the atmosphere to develop a few aches and pains of their own.

Some residents employ themselves fruitfully and faithfully in the kitchen, dining room, sewing room and carpentry shop. Since they represent a minor-

Mrs. Brodsky was a practical nurse supervisor at a home for the elderly in Ontario.

ity of the total number of residents, this is an area in which more remains to be done through a good program of occupational therapy. Theoretically, the residents are expected to keep their rooms clean and tidy. In practice this consists of straightening bed covers and making a few gestures towards dusting since the heavier cleaning is done by a regular cleaning staff.

We have also noted that a large majority of residents seem unduly concerned with the amount of sleep that they obtain. They complain that they can not sleep at night forgetting that they have spent the greater part of the day dozing, rousing only for meals. The elderly may require, as a maximum, only five to six hours of sleep. This tendency to spend too much time in sleep in all probability might be offset by an organized program of activity and recreation. The residents themselves should be responsible to as great a degree as possible for planning and carrying out such a program. Excessive sleeping might easily be a symptom of boredom and is not necessarily confined to the elderly.

Other advantages of increased activity would be greater enjoyment of their meals, and somewhat less tendency towards overweight. The meals provided are abundant, the food good.

After such a careful selection of location, it was a surprise and a disappointment to find that from the residents' point of view the locale of the home was anything but ideal! Although a grand vista of fields and woods can be seen from the windows, remarks such as "That dreadful bush! Why don't they clear it away?" were frequently heard. They missed the bustle of city life. A city-bound bus calls at the door twice daily but there is a definite need for a community service project whereby the old people could be assured of frequent outings to nearby shopping areas, theatres or other points of interest. It would do much to relieve their sense of isolation and make them more content.

Those who work with the elderly should be prepared to accept the fact that age does not change character or temperament. The person who has been exacting and selfish throughout her earlier life will show these same qualities in her declining years. So will the considerate, generous man or woman. It will help in coping with the individual resident, if as many facts as possible about him or her can be gathered from the family. Considerable tact and patience will be absolute necessities in preserving as harmonious an atmosphere as possible in an environment that features so many differing personalities and fixed patterns of thinking and doing. The latter point is an important one to remember — old age does not have the flexibility of youth. Emotional and physical adjustment is made with more difficulty.

We encountered another factor for which we were perhaps less prepared — a status factor. Some of the residents had only their old age pensions. The financial setup of the home is such that, except for a set amount of pocket money given to the pensioner out of each cheque, the major portion is retained to pay for his board, room and care. This represents a very minimal amount per week. Other more affluent guests were able to pay the full amount set by the administration. These people tended to consider themselves a small aristocracy, and their rather superior attitude was a source of friction. Again, such a situation requires careful handling so that the sensitive old people, who must get along on smaller incomes, retain their personal dignity and self-respect. The same consideration must be shown in helping the old age pensioners to accept the fact that their cheques are no longer under their control. It does reduce their sense of being independent and this may come out in their complaints that they are paying for more than they receive.

The idea that husband and wife should not be parted in the sunset of their lives is an appealing one, that the provision of apartments acknowledges. On occasion, two elderly residents will marry in the home. While we might like to think that these are instances of true, if late-blooming romances, we must be realistic enough to admit that sometimes the attraction of the apartment plays a part. Human nature being what it is, some of the unmarried residents consider the comfort represented by the extra space an undue reward for spouse survival or acquisition!

An elderly person who is mildly

confused can usually manage fairly well under familiar conditions which make no perceptible break in her life-long pattern of living. She can take care of her own personal needs — use the toilet, wash her hands, don an apron and sit down to a meal — automatically and without fuss. Familiar faces greet her. True, she is uncertain if the man opposite her at dinner is her son, grandson or late husband but his presence and smile reassure her that everything is as it should be.

If this person is uprooted and placed with other confused people, in a matter of months she will deteriorate. A plump, smiling prosperous-looking lady becomes a sunken-cheeked harried-looking creature who appears ten years older; or a benevolent, cheerful chatty old gentleman, soon develops into a silent wraith, immobile and gazing into space. As time goes on these patients becomes too inert to come to meals or use the toilet without constant and often fruitless urging. This is an effective argument against segregation of the confused person unless it is absolutely necessary.

The provision of an infirmary in the home is primarily for the purpose of providing incidental care for residents who otherwise enjoy reasonably stable health. As might be anticipated, a certain number of the old folk tend to become "chronic" infirmary patients. They appear with great regularity to recite their symptoms but again, one might suspect that their greatest need is not a pharmaceutical remedy but an increased dose of T.L.C.

No home is better than its nursing staff. However efficient the supervisor of nursing may be she is very dependent on a minimum staff of registered nurses and a number of practical nurses whom she endeavors to direct in the best interest of the residents. Unfortunately, registered nurses who are physically active and experienced are not usually attracted to this type of employment. A home for the aged may have to depend on nurses who find the rush of the general hospital beyond their capacities or on married nurses with families to care for. A few are attracted by the greater freedom in the working conditions, not possible in highly regulated hospital life.

The right type of applicant for the practical nurse staff is even more difficult to find. Strict hospital discipline is not possible in a home. The few registered nurses who are responsible for the performance of others may be fearful of being called to task if their disciplinary action causes a practical nurse to resign. Labor is difficult to replace and administration does not relish continual turnover of staff.

Conclusion

In our parents' or our grandparents' day, homes for old people were unknown. The younger members of the family and the elderly father or mother lived together in a house built with an eye to future needs in accommodation. The present need for homes for the elderly represents a trend in social conditions. Small houses and apartments cannot usually accommodate an extra member of the family. Even if there is a room, the elderly person may not be happy living in crowded quarters with a young couple and their children. If an aged person is well and wishes to live alone, even in one room, the family may feel guilty and decide that their relative would be better in a home with others of her own age. This attitude frequently implies a lack of understanding of the needs of the aged to retain independence and dignity. An awareness of the needs of the elderly is the family's most important responsibility.

The story of Mr. Smith is typical:

He was a violent-tempered, pinched-face little man who spent most of his time in the home lying on his bed. He often threatened staff members with his crutch when they came near him. A relative removed him from the home and one day he was seen on a city bus by a member of the nursing staff. He chatted happily with her and pointed out his solitary housekeeping room as the bus drew up to the curb.

As he was about to descend from the bus the driver told him that he must not try to ride on the bus again without a ticket. Mr. Smith became enraged, as he had often done at the home, but he did not attempt to use his crutch as a weapon. He stomped out of the bus, allowed the driver to hand him down his well-filled shopping bag, and then held up the bus while he walked majestically in front

of it toward his lodging across the road.

The world is usually kind in making allowances for the handicapped and both benefit immeasurably. The violent temper could be controlled and the development of a feeling of self-sufficiency made it possible to replace perpetual lying in bed with shopping trips and some measure of normal activity.

Hospitals, for those who are not acutely ill but need some nursing care, are necessary and should be available to all who need them. The decision that an elderly person needs to be institutionalized should be made by a board of experienced medical men. An "incurable" condition does not necessarily imply an inability to play a comparatively normal role in community life, even if the role is an increasingly passive one.

Many of us will live to become elderly — not necessarily confused or "incurable." Let us not create ever-expanding little communities of senior citizens. If they are allowed to keep their known patterns of living at a time when change is so very difficult, they would not become a burden to themselves or to others.

Nursing Home Care in Geriatrics

Isobel V. Scriver

Geriatric nursing is not for every nurse. Would you like to try? Are you suitable?

Geriatrics has been defined as "the medical treatment of the aged" and "the branch of medicine which relates to diseases of old age." The Geriatric Centre in Saskatoon does exactly that — gives medical treatment to the aged and their diseases. The centre is rehabilitative in that patients are encouraged toward self help.

In recent years we have been able to look at the brighter side of old age and no longer think that reaching the "eventide of life" is so frightening. The rocking chair, as a symbol, has been discarded; yet in some instances a too glowing picture has been painted. While these years are not necessarily ones of physical and mental deterioration in which little can be done, neither are they an earthly paradise or a golden age when nothing *needs* to be done. To work effectively with older people, our attitude must be realistic.

An understanding of the emotional problems of older people requires consideration of the stresses of later life and their effect on previously existing personality structures. The most common stresses are physical and mental limitations or disabilities. These have been brought on or aggravated by retirement, diseases which cause helplessness, loss of a mate, relative or close friend, rejection by their own children. Some are subjected to few hardships, others to heavy ones, but the effect on the individual varies. The type and degree of stress is not necessarily proportional to the effect. The individual response depends on previous patterns of response to stress.

The Geriatric Nurse

The nurse in geriatrics does not need personality characteristics or abilities that are different to those of nurses in other fields. It is the degree to which she must use certain abilities that is increased.

She needs to have:

1. *Sympathy, kindliness and thoughtfulness* without pity.
2. *A sense of humor.*
3. *Patience and tact,* for the aged become garrulous and somewhat unreasonable at times.
4. *Flexibility,* since most older people are fixed in their ways. If, in our attempt to cure, we try to change them, we achieve little more than making them unhappy. Frequently unhappiness causes confusion.

Miss Scriver is director of nursing services at the Geriatric Centre, Saskatoon.

5. *Teaching ability.*

6. *Physical energy* and the ability to use it wisely.

7. *Well-developed powers of observation* so that she can recognize the emotional needs and signs of worry in the aged patient. Worry and fear may be alleviated by explanation or by allowing the patient to talk and express his fears. If a nurse becomes well-acquainted with the patient's history and family background she will be able to help him to adjust to a new way of life in the nursing home.

8. *Adaptability* to meet the particular needs of each guest. Not all old persons are deaf — the belief that they are is deplorable. Many have hearing limitations which are overcome if one speaks slowly and clearly. The nurse should face the patient and stand in a good light in case he is dependent on lip reading.

9. *Judgment* in answering questions, knowing when to refer queries to the doctor and answering those within her field in language that is readily understood. An old person who is ill and clutching at the hope of recovery and self-sufficiency may easily misinterpret statements made by the doctor or nurse.

Forgetfulness, so common in senility, is the senile mind's way of protecting itself from painful memories. We have been amazed by the elderly gentleman who could not find his way home from a neighborhood grocery store but could repeat accurately the details of a football game that took place 40 years ago. The explanation is simple. The man enjoyed remembering the happy times but the same man, who retired as a plant foreman to become an errand boy for his wife, sub-consciously finds it so painful to return home that he cannot remember his way.

The nurse who takes the trouble to get to know her aged patients may frequently benefit from a philosophy of life which only the passing of years can bestow. However, it must not be assumed, because a person has lived many years, that he is necessarily mature emotionally.

Maturity is not a matter of years. Each person will respond on the basis of his or her personality, and this individuality is of primary importance in planning nursing care.

The personality reactions of the aged are not only individual but are based on the mode of another era. An elderly person may be liberal and tolerant of his own era but he may also have reactions that, through time, have become a set pattern. These cannot be changed without causing considerable stress.

If grandfather has been in the habit of sleeping in his underwear all his life, he is certainly not going to wear pajamas at 80 years of age when he is admitted to a nursing home. Nurses in a home for the aged have to learn that such habits are of minor importance to nursing care, but are of major importance to the patient if he is expected to give them up. We have to adjust ourselves to our patients, not they to us.

The aged need attention, affection and to be heard. They are individuals, the same as we are. It is like looking into a mirror and seeing ourselves in years to come. If we educate ourselves to meet this phase of life, then it should not be too hard. We cannot escape. We must all grow old. Let us prepare ourselves to do it graciously.

SLOW DOWN AND LIVE!

1. *Keep your car in top condition.* Steering gear, brakes and lights are especially important. Watch your tire pressure. Improperly inflated tires + hot summer roads = blowout disaster.

2. *Keep your eyes on cars behind and in front of you.* Anticipate what the other driver may do and keep your distance — a car's length for every 10 miles of speed.

3. *Stay alert.* On long drives stop q.2. h. for coffee — iced is as effective as hot. Walk around and relax for a few minutes.

4. *Share the wheel.* Don't fight fatigue. Pull over to the side of the road and take a rest.

5. *Know and obey traffic regulations.* Speed, too fast for conditions, is the most common cause of highway fatalities.

— Canadian Highway Safety Council

UMBILICAL HERNIA

ROSEMARIE PERKA

A patient's attitude toward illness, his willingness to cooperate and the extent to which he trusts the efforts of those who care for him can be major factors in recovery.

Sociological History

Mr. Dion was the eldest son of a French-Canadian family. At 22 years of age, he married a girl almost his own age, and from this union were born nine children, three sons and six daughters.

He appeared to have devoted his entire life to his wife, children, and grandchildren. His ability to give to others instead of to receive was evident in the way he kept up the morale of his roommate and brought cheer to the staff or anyone who visited him.

Mr. Dion lived on a farm near his birthplace for almost 50 years, after which he moved with his wife and family, to a farm in one of the Western provinces. Two years ago he gave his farm to his youngest son and his family, and bought a house in a nearby town where his wife and he are living presently. He was, at first, quite reluctant to leave the farm but, as he said, "I was getting too old and stiff to be a good farmer."

His attitude towards his retirement was one of complete acceptance. He began keeping a large garden of flowers and vegetables, his favorite crop being his bountiful potato patch. By these activities, he has been able to compensate for his retirement and still remain happy and satisfied. He has many friends in his neighborhood whom he visits occasionnally with his wife.

Mr. Dion receives the old age pension and his hospital stay was entirely free from financial worry. Probably this was one reason why he appeared so cheerful. Since a cause for worry had been eliminated, his recovery was hastened.

Reaction to Illness

Since Mr. Dion was admitted through the emergency department and had to have his operation almost immediately, his family were very concerned. However, as soon as the urgency of the hospitalization and surgery had passed, the strain and tension diminished rapidly. Instead of sending flowers or candy, they arranged to take turns visiting him so that he was never alone during visiting hours. Doing small things, such as giving him a haircut or shave, and bringing him little bits of his favorite foods replaced the more extravagant outward show of affection. His family's constant and loving thoughtfulness certainly affected Mr. Dion's recovery. He was always jovial and had a smile for everyone.

His personal reaction to his surgery and hospitalization was one of willing surrender to and total cooperation with his doctor and members of the hospital staff. His faith in his doctor had no limit, and he was eager to help in any way he could. His attitude to his illness had a definite influence on his quick recovery since he did what was asked and expected of him and refused no phase of his medical or nursing care.



ROSEMARIE PERKA

Miss Perka, a student at Edmonton General Hospital, received a $25 prize for her study in this year's Macmillan Award competition.

Mr. Dion did not worry about how his surgery would affect his future. Rather, he began slowly to mold his pastimes into a pattern that would be of most benefit to him. He planned to have a much smaller garden and to eliminate heavy work from his daily routine. In addition, he intended to try to relax for a short while after his meals, and especially during the afternoon. He fully understood how his operation would affect his activities.

Physical History

Mr. Dion's first admission to a hospital was nine years ago when he was admitted with a diagnosis of benign prostatic hyperplasia. A suprapubic prostatectomy was performed successfully, and he recovered quickly with no after-effects.

Six years ago he developed an attack of influenza and suffered from severe coughing spells. During one of these spells he felt a sharp pain in his abdomen and noticed a bulge just below his umbilicus. This bulge was not troublesome, so Mr. Dion did not seek medical attention. A few days prior to this admission, the hernia became tender and appeared slightly edematous. Mr. Dion began to lose his appetite rapidly. The day of his admission he had severe abdominal pain with nausea.

An umbilical hernia is a protusion of a loop of intestine through the umbilical ring. It is caused either by the failure of the umbilicus to close at birth, or by a congenital defect in the umbilical scar. The weakened muscle wall may then open due to increased intra-abdominal pressure such as pregnancy, intestinal obstruction, or as in this case, a severe cough. Umbilical hernias are common in obese and elderly people.

Because Mr. Dion was admitted through the Emergency Ward, there was little time for routine tests. A specimen of urine was sent for a complete urinalysis. The results revealed a slightly abnormal urine content.

The color was clear yellow which was normal.

The specific gravity was 1.012 and within the normal range of 1.010 - 1.030.

The pH or acid-base reaction was 5.3, the normal being 5-7 and slightly acid. It was negative for the presence of sugar and red blood cells.

Protein was present in small amounts indicating, in this case, a form of either glomerulonephritis (primary involvement of glomeruli) or nephrosis (primary involvement of tubules.) There were occasional casts in his urine — an abnormal finding that is due to some form of kidney injury. Casts are tiny masses of material that have hardened in the tubular lumens and therefore assume the shape of the lumens.

The only other abnormal constituent present was occasional pus cells, indicative of infection in either the bladder or renal pelvis.

Medications

Preoperatively, Mr. Dion received 500 mgm. achromycin in each 1000 cc. of intravenous solution. Achromycin is a highly efficient antibiotic, effective against Gram-positive and Gram-negative bacteria, as well as many other types of microorganisms. It is preferable to most other antibiotics because it produces fewer gastrointestinal disturbances — a very important factor in Mr. Dion's case as there was less likelihood of strain on the suture line. Achromycin can be given orally or intramuscularly in doses of 50 to 250 mgm. three or four times a day. Its only toxic symptom is diarrhea. This is usually too mild to warrant cessation of the administration of this antibiotic. Achromycin was given to help prevent wound infection and to clear up the urinary tract infection that may have been responsible for the presence of pus cells in the patient's urine.

Preoperative sedation consisted of Demerol 75 mgm. and atropine gr. 1/100, given one hour in advance of operation. Demerol is less likely to cause gastrointestinal distress such as nausea, vomiting, and respiratory depression. It is used to relieve distress associated with spasms of smooth muscle. Atropine relaxes smooth muscle tissue.

As a general anesthetic was being used, an intravenous solution of 10 per cent Travert in water with achromycin 500 mgm. was started in Mr. Dion's right arm. This was established because, until normal peristalsis returns, both food and fluids are restricted orally postoperatively.

Morphine sulfate gr. ¼ was ordered q.4h., p.r.n. for postoperative discomfort. Morphine sulfate is one of the most reliable drugs for relief of severe pain, and in this instance it was used espe-

cially to decrease intestinal peristalsis and allow healing to take place.

Treatments

Abdominal surgery requires the use of a continuous Wangensteen suction since it is desirable to keep the gastrointestinal tract empty and at rest until normal peristalsis resumes. It is an effective method of removing the secretions, air or gas which often accumulate in the gastrointestinal tract following abdominal surgery. Suction, then, prevents distention.

Before Mr. Dion was taken to the operating room a Levine tube was inserted into his stomach. He had continuous suction for three days during which time it drained a small amount of brownish yellow fluid.

While the Wangensteen suction was in operation a total of 6500 cc. of intravenous fluid was given. Immediately following surgery, he received 4000 cc. of 10 per cent Travert in water with 500 mgm. achromycin in each 1000 cc. of solution. The Travert in water helped maintain a high nutritional standard. In addition, to the glucose solutions, Mr. Dion was given 2000 cc. electrolyte No. 2 and 500 cc. of normal saline to ensure adequate electrolyte balance.

He also received an oil enema. This was to soften feces and lubricate the anal canal. Because Mr. Dion had not received a preoperative enema, he became constipated postoperatively and was unable to expel the oil until the next day. The enema was effectual. A considerable amount of flatus and a large amount of soft brown stool was expelled with the oil. This indicated that peristalsis had been regained so Mr. Dion was able to take food and fluids orally.

Diet

On the third postoperative day the Levine tube was removed and the patient received fluids orally. At first he was given one ounce of water q. ½ h. On the fourth day he received clear fluids such as apple juice, tea and jello. The fifth day, he began a soft diet which consisted of eggs, white toast, broth, ice-cream, milk, tea, cream of wheat and jello. Two days prior to his discharge from the hospital, he was placed on a light diet. Mr. Dion accepted his diet well. He was at no time nauseated after eating. At the time of his discharge he was on a regular diet and was able to eat all foods, which pleased him greatly.

Nursing Care

The *preoperative care* was carried out in the emergency room. A major and minor skin preparation was done by an orderly shortly before surgery. Green soap was used to cleanse the skin before shaving, and ether and alcohol were used to paint the area afterwards.

Fasting before surgery to prevent nausea and vomiting from the anesthetic is customary. However, he stated that he had only eaten a small dinner that day, and had had an emesis following it.

Mr. Dion voided immediately before operation. This eliminates displacement of the abdominal organs due to a distended bladder, and prevents accidental injury to or rupture of the bladder during surgery.

Surgery: After anesthesia was established, the surgeon made a transverse incision just below the umbilicus to expose the herniation. The hernial sac was removed, the bowel replaced in the abdomen and the peritoneum closed. To prevent recurrence of the hernia and to facilitate closure of the defect, a hernioplasty was done by suturing stainless steel mesh to the fascia to strengthen the muscle wall. The skin layers were then closed with interrupted mattress sutures.

Postoperative care: Mr. Dion was brought to the ward immediately following his operation. As soon as he was settled comfortably in his bed, his blood pressure, pulse and respirations were taken at 15-minute intervals until they remained relatively stable.

He was given morphine sulfate gr. ¼ to minimize pain and discomfort and to allow him to rest quietly throughout the night. He received this narcotic the following afternoon for pain in the operative area, and again at bedtime for three consecutive evenings to ensure a good night's rest and reduce peristalsis.

Early the first morning Mr. Dion began arm and legs exercises as well as deep breathing to prevent such postoperative complications as hypostatic

pneumonia, thrombophlebitis, and intestinal obstruction. Since he had not been taught these exercises before his surgery, it was necessary to teach him postoperatively. He was very cooperative and it did not take long before he was doing his exercises every hour without having to be reminded of them. After turning from side to side a few times, Mr. Dion realized how much more comfortable this made him feel. As he was obese, he perspired easily and his skin soon became tender. This was relieved by frequent back rubs.

He developed a cough, and to prevent any strain on his suture line, he was taught to splint himself by firmly pressing against his incision with his hands whenever necessary. He was able to cough more deeply, which was a good preventive measure against pneumonia. He was not afraid to cough or to turn in bed when thus splinted.

Mr. Dion had no trouble voiding after his operation. Two days after surgery he sat in a chair for the first time postoperatively. He was not dizzy or overly tired after this experience. This pleased him immensely and encouraged him to either sit on the side of his bed by himself or to get up into a chair if someone was present to help if needed.

Four days postoperatively he was able to take short walks about the ward without assistance of any kind. This greatly improved his morale and was an important factor in hastening his recovery. On his eighth day, one half of the sutures were removed. He was discharged the next day with an order to visit his doctor at his office the following week for the removal of the remaining sutures.

Mr. Dion left the hospital with the understanding that he would have to be careful for at least a few months after his discharge. He would not be able to move or lift heavy objects; do any tiring, strenuous labor. These limitations of activity were easily accepted. He was rapidly regaining his former strength and was confident that it would be only a short while before he would be "my old self again."

Spinal Injury and Paraplegia

EMIKO ADACHI

We may complain that our feet hurt or that our legs ache at the end of a long, busy day. But what would it be like to have to face the knowledge that we would never walk normally again?

MR. MARTIN WAS ADMITTED with a spinal injury and paraplegia. X-rays showed a fractured dislocation of the vertebral column in the dorsolumbar area. At operation the surgeon found a dislocation and rotation to the right of the facets joining the 12th thoracic and first lumbar vertebrae. A ruptured intervertebral disc was also discovered. The *nucleus polposus* or central core of the disc had herniated through the posterior ligament which supports it, into the spinal cord. This herniation caused pressure on the lumbar and sacral nerve roots and was partly responsible for the pain that Mr. Martin experienced.

Fractures of the spine may result from a disease process, or some type of injury. Accidental fractures are caused by falling while in a sitting or stooped position; by a direct blow to the spine; by falling in a jack-knife position in which case the shoulders and hips take the force of the injury.

The vertebral column protects the spinal cord and keeps the body erect. Therefore, a spinal fracture will affect the cord and its nerves. A severe dislocation of vertebrae may sever the cord causing immediate and complete paralysis below the fracture. A minor displacement may cause com-

Miss Adachi who is a student at the University of Alberta Hospital, Edmonton, was awarded $25 for this study in the recent Macmillan Award competition.

pression and pressure on the cord with a delayed response of pain and paralysis. Compression, if slight, may not cause any neurological disturbances. Sometimes the main body of the vertebra remains intact and only the lateral or spinous processes are broken. The degree and the direction of damage produce a variation in subjective symptoms. Mr. Martin had extensive cord injury. There was compression and pressure plus a great deal of soft tissue damage. Paralysis below the fracture site was evident.

Social History

The patient was 24 years old and worked as a laborer in the city. He had one sister who was a year his senior. He said very little about his family life and apparently did not get along well with his father. He felt that he was the "black sheep" of the family. He had a great deal of love and respect for his mother. He was a very congenial young man, pleasant to work with but very uncommunicative about his accident, his past experiences or his friends.

This misfortune set him back socially, physically and financially. It upset him mentally as well. He had hospitalization coverage but no medical insurance, and his accident did not qualify him for Workmen's Compensation since he was not injured on the job. He was a long-term patient and his adjustment depended upon his courage and his will power.

Medical History

Mr. Martin had always been very healthy. There was no family history of inherited disabilities or illnesses. His only previous hospitalization was for a tonsillectomy when he was a child.

His recent hospitalization was the direct result of a rather mysterious accident. He may have been the victim of a hit-and-run accident or of foul play. He did not remember, nor did he seem to wish to remember, any part of the incident. There were no witnesses. He awoke from an unconscious state to find himself lying in a ditch. It was foggy and there was no traffic on the highway. He crawled about 100 feet since he could not get up on his feet. However, he was unable to crawl up the incline of the ditch to the highway and remained by the roadside for four hours before two hunters found him. He was taken to a local hospital for preliminary treatment, and then removed to ours.

On admission his primary distress was his excruciating back pain and inability to move his legs. His blood pressure was 130/86, pulse 76. He was in psychological shock. He stated later that he could not recall anything from the time he received an analgesic in the local hospital until he found himself in the recovery room here.

He was examined, x-rayed and immediately prepared for an emergency operation. His hemoglobin was high — 96 per cent or 14 gm. His urinalysis was essentially normal. He had slight dyspnea but no cough and his lungs and chest were clear. His abdomen was soft and tender; bowel sounds were present. He did not seem to have any internal abdominal or thoracic injury. There were no signs of cardiovascular disease. All cranial nerves were intact. There was no history of headache, dizziness, visual or aural disturbances. Mr. Martin had good arm coordination, power, sensation and reflexes but he had complete leg paralysis and weak muscle tone. He had no sensation from waist to toes. Reflexes were absent. His back pain was localized in the midline of the dorsolumbar region. There was a slight blood discharge from his nose.

Following operation, further laboratory tests were taken for postoperative comparison. The urinalysis remained essentially unchanged, with some red blood cells present in the sediment. The white blood count was slightly above normal at 11,300 but not a sufficient rise to cause alarm. The red blood count and platelet count appeared normal. His hemoglobin was slightly reduced to 80 per cent. The sedimentation rate was increased to five times above normal at 50 mm. per hour. An increase is indicative of infection or an inflammatory condition. A portable x-ray of the thoracic and lumbar regions showed that the dislocation of the spine had been reduced.

Later x-rays indicated a slight compressed fracture of the first lumbar vertebra but no evidence of dislocation. The alignment appeared within normal limits. The disc space between the injured vertebrae was still narrowed.

Treatment and Nursing Care

Preoperative care: Great care must be taken in the first aid treatment of spinal injuries at the scene of the accident. Caution should be used in transporting the patient in order not to flex his back. Improper handling and positioning aggravate the injury.

At the local hospital Mr. Martin was given 100 mgm. of Demerol to relieve his severe back pain. After appraisal of his general condition he was transported by ambulance to this hospital with a referral to a neurosurgeon. Upon admission he was examined, prepared for surgery, measured for a Stryker frame and a Levine tube and Foley catheter were inserted.

If Mr. Martin had not been an emergency admission the preoperative care would have been more "patient-centered" rather than "surgery-centered" as in this case. There would have been more time to prepare him physically and mentally for an operation. The routine care of an enema, tub or bed bath, fasting after midnight, would have been observed. He would have been given a more adequate explanation of the Stryker frame and its advantages, and helped to adjust mentally as well as physically to a new and different routine. When a patient acquires a basic knowledge of his condition and can accept his circumstances, he is better equipped to face surgery and postoperative treatment. A well prepared preoperative patient makes a more cooperative postoperative patient. The postoperative routine and the patient's responsibilities, such as deep breathing, coughing, should be discussed. The significance of drainage tubes requires explanation. The patient needs to become acquainted with the ward routine as well. In this instance only essential data were compiled. Mr. Martin was sent to the operating room without preoperative sedation since he had received Demerol several hours earlier.

He was anesthetized with sodium pentothal by intravenous injection and then placed in prone position. Anesthesia was maintained with pentothal, nitrous oxide, oxygen and Demerol. Demerol in divided doses up to 65 mgm. was given throughout the operation to raise the pain threshold, to promote spasmolytic effect and thereby reduce nerve and muscle irritability in order to lessen the anesthetic required. Hyoscine gr. 1/150 was administered intravenously to reduce gastric and salivary secretions and the tendency to vomit under anesthesia. Adrenalin was given to decrease the amount of peripheral bleeding by constricting the peripheral blood vessels. Intravenous therapy of 5 per cent glucose in 0.2 per cent sodium chloride solution was started to keep a vein open for the administration of drugs and in the event that a transfusion was necessary. Dextran, 500 cc., was used to expand plasma volume, to maintain blood pressure and to lessen the possibility of shock. To promote muscle relaxation Succinyl 0.1 per cent was given and maintained with an Anectine drip 0.1 per cent.

The neurosurgeon performed a laminectomy to reduce the dislocation between the 12th thoracic and first lumbar vertebrae. This relieved some of the pressure on the spinal cord. The intervertebral disc was also removed with debridement of the surrounding soft tissue and insertion of a nylon graft. The spinal cord was stabilized by wiring the spinous processes together.

Postoperative care: Mr. Martin was placed on the Stryker frame and remained in the recovery room until he was conscious and responding well. His Levine tube was clamped when he began taking sips of water without any signs of nausea. Vital signs were recorded every hour to make certain that he did not go into surgical shock or begin to hemorrhage. They remained fairly stable. The intravenous injection was discontinued.

Early in the evening following surgery Mr. Martin felt nauseated and vomited approximately 150 cc. of mucus and blood-tinged fluid. His Levine tube was reconnected until his nausea subsided. During the night he had no further nausea. His Levine tube was clamped without ill effect and he drank moderate amounts of fluid. His catheter drained well and upon irrigation the return flow was clear. A routine postoperative urine specimen was sent to the laboratory in the morning to determine if there was any liver damage due to anesthesia.

Throughout the evening and night Mr. Martin's blood pressure was sta-

ble, his pulse strong and regular. His pupils were equal and reacted normally. He was immediately started on a routine of regular turning every two hours. Frequent change of position and good skin care are very important to the paraplegic patient in the prevention of bedsores and other complications. Daily nursing care included a complete bath each morning and observation of the condition of the skin and his dressing. The turning routine was arranged so that he was in a prone position for meals and on his back during the morning for elimination purposes and, later, for visiting hours.

The Stryker frame has definite advantages. It facilitates nursing care in that the patient can be turned frequently with a minimum of discomfort to himself and of time and energy for the nursing staff. Body alignment, which is of utmost importance in this type of injury, is easy to maintain. Drop foot may be prevented by means of the foot-piece. The risk of complications such as pneumonia, kidney stones and circulatory disturbances is minimized.

The few disadvantages are that the frame is fairly narrow and not so comfortable, at first, as a bed. The patient may have difficulty in adjusting if he has been in the habit of sleeping on his side. Mr. Martin encountered this problem.

Care must be taken that the patient is held tightly between the frames during turning with his arms folded around one frame. He should be turned smoothly and fairly quickly by two nurses and the stabilizers replaced immediately.

During morning care, on the first postoperative day, there was no visible oozing on Mr. Martin's back dressing. A moderate amount was noticed on his nasal dressing. His hemoglobin was checked and found to be 98 per cent. Considering the psychological shock and the strain occasioned by a lengthy operation, Mr. Martin progressed very well postoperatively. The first three or four days called for courage and determination. Supportive nursing care, physical, mental, and emotional was essential.

When Mr. Martin's vital signs remained fairly constant, they were checked and recorded less frequently. At times his respirations were irregular and he appeared short of breath. During the first evening he perspired profusely, probably as the result of tension and pain. Although his temperature remained normal he was placed on antibiotic therapy. Oral penicillin tablets were ordered t.i.d.

He suffered continual severe pain. Demerol 100 mgm., was given intramuscularly q.4h. to relieve it. Sleep is not usually induced with Demerol so for sedation Mr. Martin received seconal gr. 1½, a short-acting barbiturate.

On the second postoperative day the Demerol was discontinued to prevent tolerance or habituation. Aspirin and phenacetin compound with codeine gr. ½ tablets ii, q.4h. p.r.n. were substituted. Occasionally, in the days that followed, Mr. Martin's back pain became so excruciating that Demerol was ordered. Phenobarbital gr. ½ t.i.d. was given for postoperative tension and restlessness.

Three days postoperatively, Mr. Martin had an incontinent bowel movement. Incontinency is one manifestation of spinal injury and results from impairment or loss of control of the anal sphincter. Other complications that appeared later were constipation and fecal impaction due to sluggishness of the gastrointestinal tract. He was given Dulcolax tablets ii daily. This preparation creates or stimulates normal peristalsis. A soapsuds enema was ordered every second day to cleanse the bowel and reduce complications.

As Mr. Martin's pain lessened in severity, he became more cheerful. Sparine 25 mgm. t.i.d., was prescribed to relieve apprehension, anxiety and agitation. Once past the acute postoperative phase, he began to do some of his own morning care, to read, and to take a greater interest in his surroundings. The patient's morale falls to its lowest ebb when he has nothing to do and has time to think about himself. He must be helped to acquire a positive approach to health and to his future. His nurses can give him hope, reassurance and encouragement.

When Mr. Martin's sutures were removed, the incision appeared clean and well-healed. A dry dressing was applied. About 10 days after his oper-

ation Mr. Martin complained of severe pain in his bladder. It was irrigated and the following morning a urine specimen was sent to the laboratory. The report showed numerous bacterial and pus cells present. This indicated infection of the urinary tract. Catheter drainage was checked carefully and the urinary output was in normal proportion to his daily intake of fluids. Prevention of urinary infection is very essential since it is a major cause of death in paraplegic patients who survive the initial shock and trauma. Usually these patients have a urinary problem due to sensory and motor nerve loss to the muscles and sphincters. The indwelling catheter solves the problem of retention and distention. The patient with an indwelling catheter must be placed on recorded intake and output. Fluids are forced to over 2500 cc. daily, in order to maintain good kidney function.

In caring for the patient with a catheter good aseptic technique is very important. The amount and color of the urine must be checked, the drainage bottle cleansed and rinsed daily and the tubing sterilized regularly and changed as necessary. Washing and general cleanliness of the perineal area is essential.

Mr. Martin had more difficulty with his catheter about two weeks later. It became blocked and his abdomen was very distended. His catheter was changed and this gave him relief and improved drainage. The incident depressed him considerably.

Rehabilitation

Mr. Martin became rather withdrawn after his doctor had told him that his chances for the return of sensation and motor power in his legs were slight. He began receiving physiotherapy daily. His muscles and limbs were put through a normal range of motion. This stimulated circulation, helped in retention of muscle tone, and prevented contractures. Exercises were given to strengthen the muscles of his abdomen, back, shoulders and arms. These muscles are important in instituting special rehabilitative techniques for they act as the "work horses" in helping the paraplegic patient to walk again.

Shortly before he was taken off the Stryker frame Mr. Martin was ordered to go on the standing board in the physiotherapy department. It was explained that this placed his weight on his legs and helped to maintain muscle tone and improve circulation; that it helped to promote normal kidney function by prevention of stasis and the formation of renal calculi. He was strapped to the table and gradually brought to an upright position. This was his first step in special rehabilitation. Rehabilitation is a science of "continual progress" in which a disabled person is taught to "regain his maximum physical, mental, social, vocational and economic usefulness." The person as a whole is considered and treated. The aim is to help the patient help himself. Nursing care and rehabilitation have the same basic foundation but the latter is more specialized and is directed to handicapped people. Mr. Martin's program of rehabilitation, as with any other patient, emphasized the capabilities remaining to him.

Within a few days Mr. Martin began "sitting up" exercises and five days later he was transferred to a bed. This new status was achieved five weeks after his operation. It did not mean, however, that his troubles were over. He was still fighting a bladder infection that plagued him with malaise, fever, chills, weakness and general lethargy. Penicillin therapy was replaced by Gantrisin, a sulfa preparation, 1 gm. q.i.d. This helped to quell the infection. Bladder irrigation, changing the catheter regularly, cleanliness, aseptic technique, and forcing fluids helped as well. The same general nursing care of q.2h. change of position with proper body alignment, bed baths, back and foot care was maintained. A Balkan frame was attached to his bed so that he could raise himself to a sitting position to assist in his morning care, to eat his meals and to strengthen his arm muscles.

In approximately three weeks, through the efforts of the physiotherapists and his nurses on the ward, Mr. Martin was promoted to an even more independent state. He had access to a wheel chair, courtesy of our social welfare worker, and he began to move about the ward, the physiotherapy and occupational therapy departments by

himself. He continued with an extensive program of exercises and started to stand by himself between the parallel bars. He also practised a routine of "daily living exercises" in which he learned to dress himself, to move from his bed to the wheelchair, from the wheelchair to the toilet etc. While this program was initiated in physiotherapy it was performed regularly on the ward and each day he became more independent and self-sufficient.

Mr. Martin appeared to adjust to hospital life and to accept his handicap but he had a mental block toward social or community life. He was afraid to be discharged. He had a big adjustment to make in the field of recreation and future employment. He did not particularly care for reading, listening to the radio, watching television or doing occupational therapy. His interests were in outdoor work, dancing and active sport. He would not be able to return to his former job and he had to consider other types of work. It seemed probable that he would complete his high school education and take further studies in accounting, bookkeeping or vocational training for work that did not require the use of his legs.

Conclusion

Mr. Martin's injury caused permanent damage to his spinal cord and he will continue to be paralyzed from his waist to his toes. In a spinal injury the lower the lesion is, the better the prognosis. If the patient survives the first critical weeks against the problems of trauma, shock, severe urinary infection and bedsores he can expect to live for many years and lead a fairly active life. Rehabilitation is usually slow but the patient's will to survive and to regain mobility must be encouraged and maintained. A body without a spirit cannot maintain life and usefulness. The patient must find a niche for himself in society and he must become independent.

Mr. Martin needed assistance in the great adjustment to be made from the active life of an outdoor laborer to confinement to a wheel chair or possible use of crutches. Naturally, he experienced a period of mental strain and frustration during which he required constant encouragement, reassurance, understanding, patience and tolerance. At times he was very depressed and withdrawn, and the nurses had to be understanding and considerate. He needed someone who was genuinely interested in his predicament to whom he could confide his troubles and with whom he could discuss his mixed-up emotions. It was unfortunate that his family, particularly his mother, was not available, because of distance, to share this support with the nurses. He had to resolve any feelings of revenge, suicidal intent or self-pity. He must learn to live with himself to regain self-confidence, to build for his future in society once more.

In this day and age there is a greater opportunity for quicker and more effective return to active life through the science and "psychology" of rehabilitation. Much can be done for the paraplegic patients in teaching them to walk again with braces or crutches. A large percentage of those with serious spinal injuries can learn to walk with crutches and a great many can become self-supporting.

The hospital welfare workers can help handicapped people who are in need of financial assistance and employment. Those who are found to require such aid should be referred to the social service department as soon as possible. Other services that assist the handicapped include the local rehabilitation society for the physically handicapped. This society's purpose is fourfold:

1. Guidance in physical restoration to reduce or remedy the disability;
2. instruction and training for suitable occupations;
3. provision of opportunities for gainful employment;
4. provision of companionship for the handicapped and recreational opportunities suited to their needs.

The National Employment Service (under the Department of Labor) has a special placement section to provide and meet the vocational guidance and placement needs of the handicapped. There is a voluntary national foundation called The Canadian Paraplegic Association that undertakes to provide treatment, care and financial assistance to the paraplegic. This association re-

ceives its funds from the individual provinces. The Canadian Vocational Training Service under the sponsorship of the Department of Education aids the handicapped to become trained in some suitable type of vocation. Mr. Martin was informed that such services and aid were available to him so that he did not need to become upset over financial worries, in particular, and could plan for the future with greater ease and confidence.

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The Scope of Professional Nursing

Lucy D. Willis, M.A.

Every year hundreds of young graduates repeat "I solemnly pledge myself before God and in the presence of this assembly to pass my life in purity and to practice my profession faithfully . . ." But what is my profession? What is nursing?

Some wag has said "nursing is what nurses do." This might be funny if it was not so close to the truth. Many times in the past few years I, like many of you, have collided head on with this question. A young applicant said recently "Tell me, what is nursing? Someone told me the nurses' aid does everything for the patient now. Is nursing worth while entering if I want to help other people?"



Lucy D. Willis

Miss Willis is assistant professor at the school of nursing, University of Saskatchewan.

As president of a provincial nursing association questions came to me from members, who apparently were not sure of what their job entailed. "Nursing is what nurses do" is a dangerous answer to this type of question. "Is it all right for me to give an anesthetic?" or "start an intravenous?" or "do immunizations?" "Can I say an infectious case cannot be admitted to the only single room near the nursery?" Associations also have to answer less personal questions. "Is this institute in a nursing problem area or does it belong to management and the hospital association?" "Is this a legitimate use to make of funds held in trust for our members?" "Is this extension of nursing services within our legal territory? Are nurses protected when they do this thing?" Haven't you often wished for a rule, a list, a delineation, or a limitation?

Unfortunately, in Canada nursing is not clearly defined legally. None of the nurse practice acts tell what nursing is. Fidler and Gray state:

> At present, we have to rely on the somewhat vague generally recognized conception of nursing practice; and this

makes it necessary for the nurse at least to be clear on what nursing is not. Many things which it would be illegal for a nurse to do on her own responsibility are perfectly proper when done under a physician's direct supervision.[1]

and again:

There is an increasing tendency for nurses, especially in small hospitals, to take over certain duties which have formerly been done only by doctors. The commonest of these is intravenous injection. The fact that it is quite easy to train a nurse in the technique of this treatment is not the point; nor is a shortage of doctors the responsibility of the nursing profession.[2]

The "vague generally recognized conception of nursing practice" probably fits into the following description. The doctor diagnoses and treats the patient. He delegates to the nurse the carrying out of some of the treatments. The nurse must do these with care and prudence. The nurse has other functions relating to the comfort, general hygiene and routine needs of the patient, which, except in unusual situations related to the diagnosis, are done independently of the doctor's specific orders. Frequently, but not universally, the nurse does independent health teaching, including specific, non-therapeutic health care related to the illness. She is expected to manage the patient's daily regime so that the highest possible level of function of all body organs and tissues is preserved. With increasing frequency and to a greater extent she is expected to carry through, if not initiate, rehabilitative measures. The many qualifying words in this description point up the need for clearer definition.

Though none of the Canadian Nurse Practice Acts define nursing, some of the American ones do. Creighton quotes one of these — the Arkansas Act — as representative.

A person practices nursing . . . who . . . performs any professional service requiring the application of principles of nursing based on biologic, physical and social sciences, such as responsible supervision of a patient requiring skill in observation of symptoms and reactions and the accurate recording of the facts, and carrying out of treatments and medications as prescribed by a licensed physician, and the application of such procedures as involve understanding of cause and effect in order to safeguard the life and health of a patient and others.[3]

Statements issued by formal assemblies give further clarification as to the nature of nursing. The preamble to the International Code of Nursing Ethics, adopted in 1953 by the International Council of Nurses states:

Professional nurses minister to the sick, assume responsibility for creating a physical, social, and spiritual environment which will be conducive to recovery, and stress the prevention of illness and promotion of health by teaching and example. They render health service to the individual, the family, and the community and coordinate their services with members of other health professions.

At the Technical Discussions of the World Health Organization, held in Geneva, May 1956, recognition was given to the fact that each country should prepare its own statement of nursing function. Those assembled agreed that there were five essential functions of professional nursing.

1. Giving skilled nursing care to the sick and disabled in accordance with the physical, emotional and spiritual needs of the patient whether that care is given in hospitals, homes, schools or industries.

2. Serving as a health teacher or counsellor to patients and families in their homes, in hospitals or sanatoria, in schools or industries. Because of her extensive and intimate contact with patients and families, the nurse usually has the confidence of the family and is in a strategic position to put scientific information into simple language which will be understood, accepted and put into practice.

3. Making accurate observations of physical and emotional situations and conditions which have a significant bearing on the health problem and communicating those observations to other members of the health team, or to other agencies having responsibility for that particular situation. Thus, the nurse is a very valuable liaison between the patient and the physician, the research scientist, the sanitarian, the social worker, the school teacher and the industrial foreman.

4. Selecting, training and giving guidance to auxiliary personnel who are

required to fulfil the nursing service needs of a hospital or public agency. This also involves an evaluation of the nursing needs of a particular patient and assigning personnel in accordance with the needs of that patient at a particular time.

5. Participating with other members of the team in analyzing the health needs, determining the services needed, and in planning the construction of facilities and the equipment needed to carry out those services effectively.[4]

Somewhat similar, but slightly more specific statements of function have been made by the Joint Commission on Nursing (U.S.A.) in 1953,[5] and by the American Nurses' Association in 1954.[6] The Joint Commission represents an organized and official attempt to get an opinion on nursing function from various experts with vested interests in nursing, for example the American Medical Association and the American Hospital Association.

Somewhat different results came from asking individual consumers of nursing for their views of what the nurse's role should be. One hospital administrator headed an article "Wanted, Managers in Nursing."[7] A doctor, who is a hospital administrator, and his assistant think the nurse should be prepared to:

carry out involved nursing procedures,

supervise as a team-leader in understanding patient needs and in planning and providing for bedside care,

supervise as head nurse, supervisor or administrator,

teach,

assume more medical and technical duties[8]

—whatever that means! We hope they do not expect this to be done in a basic three-year hospital program.

Another hospital administrator asks only that the nurse have a sense of loyalty so that she won't wander aimlessly from hospital to hospital, and pride in the quality of her work so that she won't "vegetate" if she does stay in one spot.

Historically the picture of nursing is well known. Nutting and Dock describe Phoebe, the first deaconess, in the following manner:

Her journey to Rome, the statement of St. Paul "she hath been a succourer of many and of myself also," with other historical data, point to her as having been a woman of importance and dignity.[9]

Later in the same volume, and centuries later in history, the authors describe the nurse in the dark ages. "The drunken and untrustworthy Gamp was the only professional nurse."[10]

We prefer to think of ourselves as far removed from the nurses of those heartless and repulsive days. But sociologists have a habit of showing us that our roots are really in the past, and that our present status, if not our behavior, is based on long forgotten social conditions. In a very provocative article, George Devereux traces his observations and interpretation of how nursing grew into its present role. He claims that it is built upon the structure of woman's role in the Victorian age — her dependency on direction from the man (female nurse — male doctor), her suitability for menial and manual work (housekeeping and similar work), her tendency to achieve status through good works (the "angel" nurse willing to glory in drudgery on behalf of the helpless). This resulted in trained incompetence, denial of intellectual initiative and subordination to the doctor being recognized as characteristics of nurses as a group. In addition, he contends that the true meaning of the word "nurse" was overlooked. The same word is used for care of the infant and of the ill because both are physically and psychologically dependent. The emotional value of the nurse was ignored. She is pictured as schooled in the obsessive ritual of sterilizing nipples and bottles as a substitute for breast feeding and fondling, or busy with the "swabbing of floors and throats." He issues a plea that the cold sterile atmosphere of the hospital be eliminated, that warmth and affection take its place through liberation of the nurse's capacity to love.[11]

The upgrading of nursing began on a large scale with the enlightened, energetic and dominating Miss Nightingale. Physical and environmental care was literally revolutionized. The nurse became a respectable person! Miss Nightingale's intelligence and drive produced plans that were often stupefying in their magnitude for her colleagues or those in high places whom she influenced so effectively. Yet one

can see supportive evidence for Devereux's analysis in her writings:

> discipline is the essence of training[12]
>
> and
>
> . . . God, no doubt, gives us the required patience and steadfastness to continue in our "blessed drudgery," which is the discipline He sees best for most of us.[13]

Florence Nightingale was the founder of modern nursing. But what is the modern nurse of today doing, and what do her leaders claim that she should be doing? Nurse educators give us their picture of the nurse in the curricula they provide. Braced with an elementary but fairly adequate knowledge of anatomy, physiology, microbiology, nutrition and pharmacology, and a nodding acquaintance with psychology and sociology, she is prepared to give hygienic nursing care to patients of all ages and to carry through, safely and effectively, certain largely technical procedures with the required skill, observation and judgment. Hopefully, she will consider the patient as a "whole person"; will be motivated to learn something about his background, his diagnosis and prognosis; and, keeping all this in mind, will make reasonable plans for his care and for teaching him some of the things that will help him to manage his health better in the future. She knows something of community health and welfare resources. She is able to nurse a patient at any hour of the day or night. She knows what a clean room looks like. She has probably learned a little bit about administration through her experiences, as a senior student, and something of how to be a leader and how to present a clinic or "speak in public."

Nursing service administrators give us the picture of the nurse-octopus — many arms reaching out to accomplish a multitude of loosely related duties. The Hospital Nursing Service Manual[14] listed 21 functions for the director of nursing service, 14 for the supervisor, and 15 for the head nurse. These ranged all the way from initiating policy formation to securing, storing, distributing (and no doubt counting) supplies.

Reissman and Rohrer, as outsiders looking in, describe the hospital nurse's duties as teacher, administrator and team manager, specialized in a clinical area. They say that the family is largely outside her grasp; that she is no longer responsible for total patient care since changes have shifted responsibility for dietary and housekeeping services. She is "the hub rather than the whole wheel" in nursing, and must *fit in*, rather than *control*.[15]

The head nurse, with increasing frequency, is described as a coordinator, providing for smooth interlocking of various patient care services. This predicament, in which the nurse finds herself required to take over responsibility for the "situation" which other professional workers, including that top authority, the doctor, simply visit, has been commented on by social scientists. A statement in Fidler and Gray should provide food for much thought on the matter. "It is his (the doctor's) orders that she (the nurse) has contracted to accept and carry out, and she must be satisfied that any measures which other workers suggest for her collaboration are, in fact, his delegated orders."[16] One wonders what the legal interpretation of "her collaboration" might be in the event that harm came to a patient through inadequate definition or understanding of function.

Frances Reiter Kreuter clarifies the issue of function somewhat by differentiating between nursing practice — the large field — and nursing care as a component of it.[17] Many within and outside the profession feel that the nurse in the hospital is lost to the patient. They point out that a large percentage of direct nursing care is being given by auxiliary staff, while the nurse does other things. In general, complaints are lodged against record keeping, preparing requisitions, and looking after supplies. Much, of course, has been done to reduce non-nursing duties, but much more can be done.

Close and continuous observation of the patient and passing on information in meaningful form has always been one of the primary functions of the nurse. Good communication regarding the patient's condition is dependent on knowing what is important and how to state it so that it will convey the idea accurately. The ability and knowledge required to do this is often well beyond that of an auxiliary worker and, quite correctly, is the job of the more senior worker. Certainly, in both hospitals

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- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therap 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

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and other agencies, non-nursing duties that have little or no bearing on the quality of nursing care should be given over to other workers less taxed by shortages of personnel and/or differently prepared.

However, in hospital, much of the administrative and managerial work is so closely tied in with quality of care that it is inconceivable that this part of it be given to any other worker. Whether we should retain the title of nurse for those who are several stages removed from direct patient care is worthy of some thought. Hyphenated titles may be in order!

In a study of the nursing team, one of the suggested functions of the team leader was to use her knowledge to influence the course of nursing care. It was readily recognized that, even when the team leader had limited actual physical contact with the patient, the guidance, supervision and assistance that she gave to the less prepared members of the nursing team were significant in improving the quality of care, both specifically in a single care item, and through helping the team member fill her role more adequately. Surely, in this function the team leader is "nursing," just as the public health nurse is "nursing" when she teaches relatives to care for a family member.

There is an exciting and positive side to professional nursing that is making inroads in our thinking. I refer to the area of dynamic nurse-patient relations. It is not new to think and talk about the personal qualities of the nurse. She has been described as kind, gentle, thoughtful, interested in her patient's welfare. Applicants to schools of nursing most commonly list as their primary motives a desire to help others, to relieve their suffering, to work with people. This suggests that this is the role in which they see the nurse. Lesser and Keane, in a 1956 study, report that in interviews with 66 maternity patients, before and after delivery, the most prominently expressed need was for a warm, sustaining, human presence throughout labor. Many of them saw the nurse as the obvious person to meet this need.[18]

Peplau and Kreuter go well beyond the concept of the kindly, sustaining nurse as the ultimate in good care. Peplau says that nursing is a goal-directed process, educative and therapeutic in that it leads the patient on to more effective, more satisfying and more mature behavior.[19] Kreuter suggests that the quality of nursing can be measured by the "movement of patients" from dependence through independence to personal wholeness or integrity. These developments, she states, are a product of the interpersonal relationship and are dependent on the level of communication between the nurse and patient.[20] The patient can only move if the situation permits it. Public health nurses, and more recently, hospital nurses, have included the patient in the plan of care, so that it becomes truly the "patient's plan." The approach outlined above would entail the nurse assessing, during contact with the patient, what his level of personality development is. She sets the stage so that, in his experience, personal growth along desirable lines takes place.

I see these as some of the most significant and forwarding-looking statements being made about nursing today. Over 40 years ago, Annie W. Goodrich said that we must look, not at the institutions, but at community needs to determine the essential functions of nursing.[21] Our most pressing health problem today is mental and emotional illness. As with other health problems, cure is not the economical approach. Helping people to solve their emotional, social and physical problems so that they can effectively and satisfyingly face the problems of their everyday living, can do a great deal to stabilize home, community and national life. Nurses represent the largest force in the health worker field. Universal, or nearly universal coverage, through prepaid health and sickness insurance already gives every promise of skyrocketing costs of hospitalization and other kinds of care. Note also that most schemes, to date, exclude mental illness from coverage.

Devereux, speaking of the increasing number of collegiate schools of nursing established after 1930, said he did not view this as the dawn of a new era, but rather as the decline of the old. Florence Nightingale began a new era by improving sanitary and environmental conditions in hospitals, the physical care of patients, and by estab-

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lishing an educational system. Now 100 years after her school opened, are we ready to launch a new era, one in which the professional nurse's most significant role will be establishing relationships that promote personal growth of the patient? This will be nursing for the future, for the *patient's* future.

May I conclude with these few observations. The challenge to nurses has never been greater than it is today. The opportunity to obtain intelligent, highly-motivated, enthusiastic students has also never been greater. We can go on, passively accepting whatever additional technical procedures the medical profession sees fit to hand down to us, and just as placidly relinquishing some of our less attractive ones to auxiliary nurses. We can do this, though we may always be on the brink of illegal practice, or of endangering patients through limited knowledge or understanding. We could probably become coordinators, or perhaps white-uniformed traffic policemen if we wish, regulating the coming and going of those who "do things to the patient." This has been called "controlling the situation." Or we can say that the unique role of the nurse is in the warmth of her personal, supporting presence, ministering to the patient during the time when he needs care, so that while returning to physical or mental health, he also, through an experience of personal growth, reaches or returns to satisfying levels of social and economic effectiveness. Is this what we want to do? Is this what we are prepared to do? Is this nursing?

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The stages and signs in anesthesia have been summarized on a color chart, with accompanying illustrations of the signs to observe in a patient under anesthesia. Reactions to various anesthetic agents and adjuvants employed today are included. The chart is available through the National Cylinder Gas Division of Chemetron Corporation, 840 North Michigan Ave., Chicago 11, Illinois.

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To Colonel Elizabeth Lawrie Smellie, C.B.E., R.R.C., LL.D.

The Red Chevron Club of Ottawa and District being fully conscious of your long & devoted service to fellow Canadians is proud and happy to welcome you as an honoured guest on this the 45th Anniversary of the Second Battle of Ypres.

Your inspiring leadership, in War and Peace, through the organization & conduct of Nursing Care for the wounded, the ill, and the infirm, has been of paramount importance and credit to Canada and yourself.

You have brought comfort and healing to many thousands. A sound knowledge of your profession, coupled with a true appreciation of human needs; a sympathetic and ready understanding, and a most gracious manner, have won for you the admiration and friendship of those you have served so faithfully and so well.

Sensitive of your many accomplishments & outstanding contributions, we wish you long & happy memories & we ask you to accept this modest & inadequate expression of our deep gratitude for all that you have done.

J. L. McCULLOUGH
President

Ottawa, Ontario,
April 22nd, 1960.



(Karsh)

ELIZABETH L. SMELLIE

Miss Smellie decided to continue her residence in Ottawa following her retirement from her position as Director in Chief of the Victorian Order of Nurses for Canada.

The substance in poison ivy, poison oak and poison sumac that causes the rash is called *urushiol.* It is a powerful substance that permeates leaves, stem, roots and fruit. It is invisible and can be transferred even when the plant has withered — it can go through a glove to your skin.

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Making Health Matter is the title of the 1960 summer school in health education, which will take place at the Froebel Education Institute in London, England, August 9-19. Forums have been devised at which experts will present short papers as a basis for discussion of such topics as: juvenile delinquency, the community care of the mentally ill, recent progress in medicine and the problems of public health workers.

An experimental group discussion session is planned, at which an attempt will be made to measure the effectiveness of group discussion in attitude-changing.

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ILO publishes report

The report of the study of "Employment and Conditions of Work of Nurses" is now available through the Canadian branch office of the International Labor Office, 202 Queen Street, Ottawa 4. Miss Margretha Kruse, executive secretary, Danish Council of Nurses was appointed by the ILO to assist with this study and its contents were used as a basis for discussions at the meeting of the Ad Hoc Committee on Conditions of Work and Employment of Nurses held in Geneva, October, 1958. The study is concerned with the employment and working conditions of professional nurses and auxiliary nursing personnel. As student nurses are not considered employees they do not come within the scope of this study.

Questionnaires were circulated to 67 countries and the material presented in the report covers 56 countries in all parts of the world. Included in the report are the conclusions of the ILO Ad Hoc Meeting on Conditions of Work and Employment of Nurses.

This study is available in both French and English and should prove of value to those responsible for nursing administration and service.

International Nursing Review

The ICN reports that its official publication *International Nursing Review* will now be published six times a year instead of quarterly. The subscription price is $4.50 a year.

Copies of the July 1959 jubilee issue, a valuable record of 60 years of ICN history, are still available. Nurses who missed this issue may obtain it by writing to *The International Nursing Review*, 1 Dean Trench Street, Westminster, London, S.W.1., England — the price $1.50 a copy.

WHO Conference on Study Abroad

A large number of people contributed to the WHO-sponsored conference held in Geneva last October to find answers to the question — How can programs for students in countries other than their own be made more meaningful? Three kinds of problems of international students were considered by the conferees:

problems in preparation for study abroad;

those met during the stay in another country;

the problems that arise on the return home.

A complete report of the conference is to be published this year by the WHO.

RCAF Nurses' Association—Metz

An interesting letter arrived in National Office from the RCAF Nurses' Association in Metz. In spite of the heavy changeover of staff, this organization continues to develop. Its activity is supported by about 24 nurses, and also by many of the RCAF doctors. Apart from several interesting lectures from doctors, the main activities have been in two areas.

The first is Civil Defence. With so many dependent wives and children there, an active Civil Defence Organization is in operation, of which the Association is a part. Aside from a series of lectures for nurses on first aid, nuclear first aid and emergency obstetrics, the nurses are repeating a form of these lectures to the wives. Another project, under the direction of

the RCAF, is the staffing of a Well Baby Clinic, which is greatly needed. Two other RCAF stations have developed active Nurses' Associations. Now Canadian nurses in Europe with the RCAF are quite well organized. The new Executive of the Association in Metz is as follows:

> Mrs. M. Thompson, president; Mrs. H. Courtney, chairman of program; Mrs. M. Bowes, vice-president; Mrs. E. Urquhart, chairman of welfare; Mrs. J. McLellan, secretary; Mrs. L. Soper, chairman of refreshments; Mrs. D. McLean, treasurer. The address of the Association is: HQ No. 1, Air Division RCAF, Canadian Armed Forces Europe.

WHCCY

Over 7,600 delegates registered in Washington for the Golden Anniversary White House Conference on Children and Youth. Included were 500 international delegates from 73 countries. M. PEARL STIVER, general secretary and F. LILLIAN CAMPION, nursing secretary, CNA were honored to receive the President's invitation to attend. Every ten years during the century, such a conference has been held. The purpose of the 1960 conference was

> to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity.

The Conference opened on Sunday evening with 12,000 people filling the William P. Cole Students' Activities Building, University of Maryland, to hear the President of the United States give an address. An impressive ceremony — the Presentation of the Colors — by a combined Armed Services Color Guard, the singing of the US National Anthem by William Warfield, the singing of the Milton Hershy Glee Club, and the music of the United States Marine Band made this a memorable evening.

Five concurrent Theme Assemblies were held each morning of the first three days. Speakers at the Assemblies approved our ideals and values in this changing world on the first day; assessed the impact of today's economic, social and cultural factors on children and youth on the second day; and on the third day drew attention to the effects of science, technology, population pressure and world events on children and youth.

The Assemblies were divided into eighteen concurrent forums for the second half of each morning. In the afternoons 210 workshops, of about 30 participants each, met to discuss the material and information developed in pre-conference preparation and publications and from the assemblies and forums.

On Thursday, the forums met to consider proposals developed in the work groups. The action was reported at the closing general session, held on Friday morning. However, because of the large number of recommendations, proposals and general statements (1600) submitted, the committee responsible found it impossible to have a concise summary prepared although they worked until 3:00 A.M. Therefore, these will not be available until the Report of the Conference is published. We shall await this publication with interest. It should be studied by all those interested in children and youth.

At the close of each conference, committees are set up and planning begins for the next one. The ease with which the conference proceeded pointed up the genius of the Americans in planning and organization.

International Visitors

CNA had the privilege of welcoming to Canada, Miss ALICE C. SHER, assistant general secretary of the ICN at the Biennial Meeting in Halifax, after which her plans included visits to the Provincial associations in several provinces. We look forward to receiving Miss Sher at National Office in Ottawa during her tour of Canada.

Australia was also represented at the Biennial Meeting, by Miss C. SHEILA KIRK, nursing executive officer of Hospitals and Charities Commission in Melbourne. Following her attendance at the ICN seminar in New Delhi, India, Miss Kirk was granted a Kellogg Foundation Scholarship for overseas study. During this month she will be visiting Saskatoon and Toronto for observation and consultation in the following areas: Regional Hospital Schemes, Provincial Health Programs, Nursing Service Administration and Nursing Education programs.

Provincial Annual Meetings

As you peruse these pages, some of the staff in National Office have returned to their desks, some have gone on holiday following the Biennial Meeting. It was a wonderful meeting, wasn't it? We enjoyed particularly the opportunity it afforded us to meet so many nurses from across Canada.

There are many other ways in which National Office staff can meet CNA members. One is through the kind invitations extended to us to attend provincial annual meetings. During the past few months, M. Pearl Stiver, has attended and spoken at annual meetings of the NBARN and the ARNN., F. Lillian Campion spoke at meetings of the AARN and the RNABC. Both nurses returned with glowing reports of their reception, and the many activities that the nurses of these provinces are undertaking to improve nursing service and nursing education.

CNA Publications

Nurses across Canada will be pleased to learn that the *Report of the Pilot Project for Evaluation of Schools of Nursing* is now available in French and English. The price is $3.00 per copy.

The First Fifty Years — a record of CNA history, has been revised and is now available in both French and English.

The report of the ICN Board of Directors meeting, held in Helsinki July 1959, presented by M. Pearl Stiver to the Executive Committee, has been mimeographed and is available in English.

Facts and Figures about Nursing in Canada is available in English. This booklet is a revision of the former CNA publication "General Information and Statistical Data."

These three publications are available in quantity, and without charge.

Also available is the manual *"Guide for Head Nurses in Hospitals"* and a statement on *Job Satisfaction.* Both these publications are available in French and English.

Because of the advent of these new publications, National Office is presently preparing a new publications list. This list will be published later in the *Journal.*

O.R. Safety Code

The nursing secretary, F. Lillian Campion, represented the CNA at a meeting of the Canadian Standards Association Committee on Hospital Hazards. Four subcommittees presented reports on various aspects of a safety code for hospital operating room hazards.

Most of the committee members are technical experts, including architects, engineers, fire underwriters and fire marshals. There are also doctors and hospital administrators. Federal government departments and the National Research Council are represented as are such bodies as Canadian Nurses' Association, Canadian Hospital Association, Association of Canadian Fire Marshals, Underwriters Laboratories of Canada and the Royal Architectural Institute of Canada.

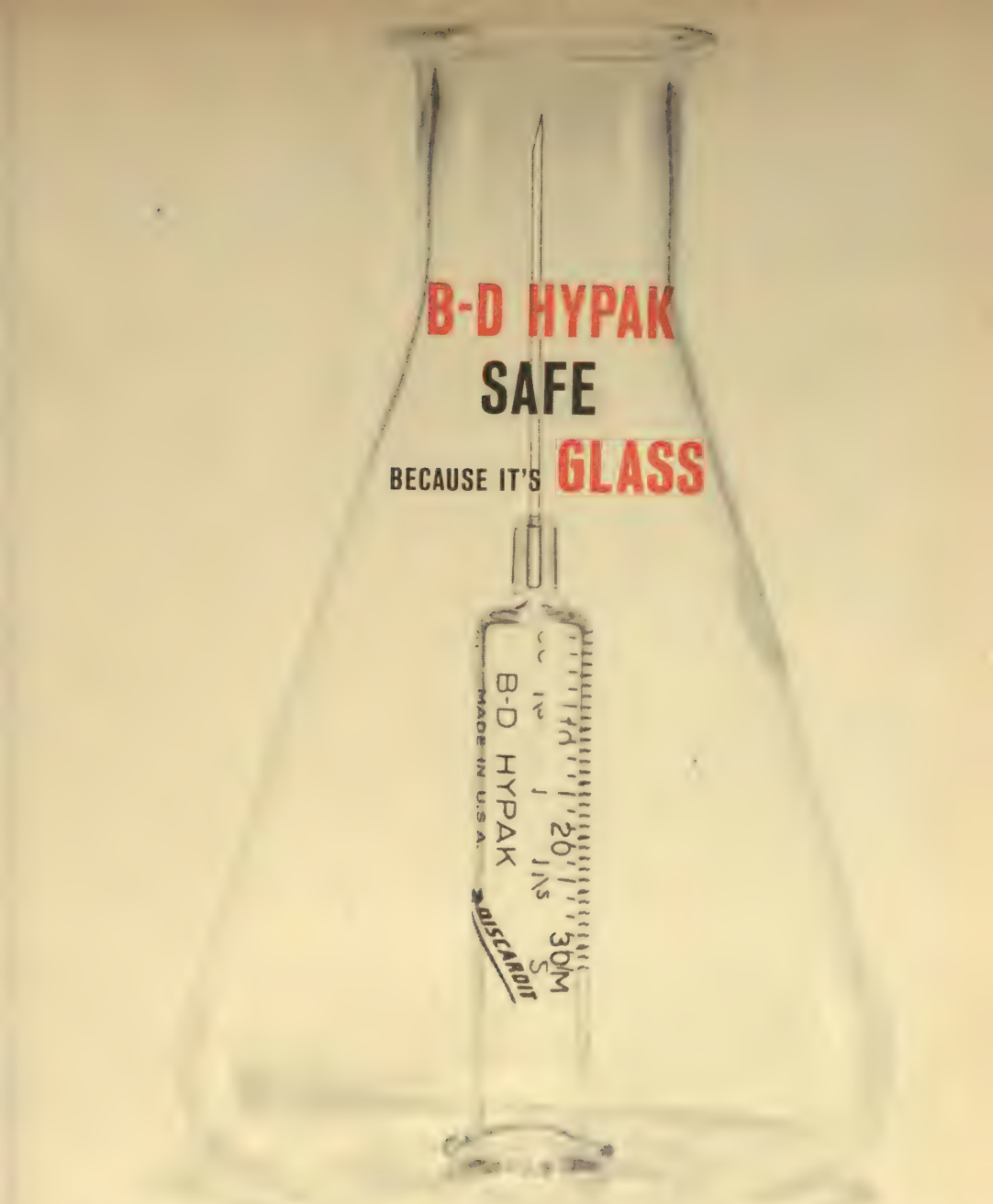
The discussions for the most part were quite technical, and one became a little confused with ohms, amperes, volts, potential arcs, KVA and sparks. Nevertheless, there was much that was of concern to nurses working in operating rooms. Some less technical items were: most explosions are due to static sparks — those caused by electrical equipment are rare. Ether is most hazardous and a very small amount can produce an explosive mixture. The safe storage of anesthetic gases and oxidizing agents was reviewed.

There was considerable discussion about the use of the term "shall" and "should," that is, whether there should be mandatory statements or recommendations. It was recognized that no enforcement of the code was possible until a provincial authority adopted it.

The editing committee hopes to have the code ready for printing in September. All nurses working in operating rooms will want to study it. A committee on interpretations will be set up to which all questions and problems will be referred.

A prejudice is a vagrant opinion without visible means of support. — AMBROSE BIERCE

To understand is to pardon.
—MADAME DE STAEL



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A HAND OUTSTRETCHED

JOSEPHINE KURIATNYK

Fifty-three years old, unhappy, alone in the world, sorely afflicted by a terminal illness — what an opportunity for a compassionate nurse to give of herself in comprehensive nursing care!

A TAXI APPROACHED the hospital's emergency entrance at a speed that defied the city's laws. The driver was very anxious to get his fare to a doctor. He helped the orderly and nurse get the lady into a wheelchair and sighed with relief when his responsibility was over.

Tessy Arno had been at a neighborhood shopping center when suddenly she became extremely short of breath. By the time she reached the hospital the dyspnea had decreased somewhat, but her pale, drawn face was full of fear.

She was admitted immediately and examined by an interne. Her emaciated face, neck and arms were in marked contrast to the lower part of her body. Her abdomen was full of fluid, easily felt on palpation, and pitting edema had risen from her feet to the level of her sacrum. In an effort to relieve her immediate distress the doctor performed an abdominal paracentesis, obtaining nearly 4000 cc. of fluid. A specimen of peritoneal tissue was taken for pathological study. A few days later the results indicated metastatic seeding of the peritoneal cavity, probably from a primary ovarian malignancy.

Miss Arno noticed the distention over two years ago. She hesitated to go to a doctor as she did not understand what was wrong with her. Ever since she came to Canada from Russia in 1927 she had worked as a cook. She felt that she had always been treated as an inferior by the society in which she lived. She had never made any friends in Canada. When her abdomen first began to enlarge she knew of no one to whom she could turn for help. Because she could not explain her bloated appearance people reached mistaken conclusions and she soon began to think that she must be peculiar.

During this two-year period she was ill on several occasions. Twice she was forced to give up her position and live on her savings. Eventually, about a year ago, she had gone to see a doctor. He did a paracentesis and advised an operation which was refused. Fear, lack of knowledge and moral support were to cost her her life.

Three months ago she gave up her position for the last time. She felt she was not wanted because she was ill and went to live in the Y.W.C.A. She deposited $295 for safekeeping when she entered hospital — the balance of her life savings!

The objectives of nursing care for Miss Arno were to alleviate anxiety and apprehension, to keep her as comfortable as possible and to prevent any complications which would add to her distress.

The day following admission she was to have her chest and abdomen x-rayed. When I explained the procedure to her she became very frightened. Although she had lived alone and kept to herself for years, her fear of going to the x-ray department alone was very real. With permission, I accompanied her. She insisted that I hold her hand on the way to the department and remain with her while the films were being taken. She needed help and encouragement to attain the correct positioning for the x-rays as it was extremely difficult for her to lie in a dorsal recumbent position.

The same fear of the unknown was evident when I explained the procedure of electrocardiograph to her. When she knew I would remain with her while it was being done, she seemed more at ease.

Many factors made good skin care essential — edema, poor circulation

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Miss Kuriatnyk was a first-year student at the Edmonton General Hospital when this study was done. It was awarded honorable mention in the recent Macmillan Award competition.

due to congestive failure, and constant positioning on the right side. I gave her a complete bed bath each morning. At first, I encouraged her to do part of her own bath, but before long she was unable to help herself. Following the bath, Zincofax ointment was applied to her back, elbows, feet, buttocks and thighs. Massage with Zincofax, cleanliness and positioning successfully prevented decubitus ulcers.

Miss Arno was encouraged to get up but movement caused such discomfort she preferred to lie quietly in bed. During the morning bath, her joints were put through the full range of motion. She learned how to tighten and relax her leg muscles to prevent phlebitis. Deep breathing exercises, to increase lung expansion, helped to prevent hypostatic pneumonia.

Each afternoon she was given a sponge bath followed by re-application of Zincofax. She was turned every two hours — but only after much discomfort and encouragement. She seemed to realize we were trying to do what we could to help her. As the illness progressed she would lie only on her right side — movement became unbearable.

Her teeth had never been properly cared for and she was nauseated frequently; special mouth hygiene was welcomed.

Her appetite was poor, as it had been for many months. Her diet at home was totally inadequate from a nutritional standpoint. She had no interest in food.

She had lived in a small room and done her cooking on a hot plate. She disliked salads and ate meat only on rare occasions. With only herself to cook for she spent a minimum of money and time on food preparation.

The high-protein, high-calorie hospital diet was very different from anything she had ever known. In her present condition it was impossible for her to change her habits — she refused her food repeatedly. Miss Arno prepared a sample listing of what she had been accustomed to eating. It was hoped that if she was served exactly what she requested she would eat something. The list was sent to the diet kitchen and she received selections from the list at each meal. She still only "picked" and often refused the food completely.

Although she understood the necessity of eating in order to maintain her strength, she made little effort. She attributed her consistent lack of appetite to bouts of nausea, indigestion and "gas." She refused a vitamin preparation and three different cough mixtures because they nauseated her.

There was such a helplessness about this patient. She said that there was no one who cared about her. She was completely alone — without family or friends. She was physically miserable and emotionally without support. She seemed to care as little about her recovery as she felt anyone else did. Recovery meant a return to her lonely life with even less financial security than prior to hospitalization.

Although she was so ill, Miss Arno rebuffed spiritual assistance. A non-practising Lutheran, she refused to see the clergyman of her faith on his hospital visits. On one occasion when he was visiting in her room, he asked her if he was a minister of her faith — she replied that he wasn't.

Medical assistance had been available for this patient when she first sought it. If she had submitted to surgery then, her chances of recovery would have been reasonably good. The Canadian Cancer Society would have been available for financial assistance during hospitalization and rehabilitation. The disease is now terminal.

Society has let one of its members down. A composite of factors — her lonely life, without friends or support from her employers, her language difficulties, her lack of understanding of her illness, and the lack of awareness of her needs on the part of those who knew her — caused her to withdraw and disregard her physician's advice. The result — a steady decline to her present tragic state.

If you want to know what God thinks of money, look at the people he gives it to.
— Anon

Born with the gift of laughter and a sense that the world was mad.
— Raphael Sabatini

Social and Mental Health

Thérèse Loriot

The term "social health" implies that an individual in the community must be considered as a total being. Otherwise, a public health nurse would not be able to render total service.

Although interest in matters of health and mental hygiene has increased markedly during latter years this very broad field is still difficult to define. The aim of mental health, dealt with here from the point of view of the public health nurse, rests especially in knowing how to track down in individuals within a community all precursory signs of emotional or mental disturbance. By being able to expose these signs at the very beginning, it will then be less difficult to discover the cause of them, and as a result, to prevent a more serious crisis.

In certain situations, the psychic strength of an individual is weakened. This phase can be more or less critical, depending on the factors which have induced it and the value of the support received at the time. These latter will determine whether or not the end result will be sure. It is during this early phase that the public health nurse will be able to function most profitably. She will direct her efforts towards building up healthy attitudes and healthy relationships between people, and will also contribute to preventing the appearance in society of new "carriers" of mental difficulties.

Without being constantly aware of it, the visiting nurse cooperates daily in observing and improving the mental state of her patients. While she goes about her routine duties, she willingly listents to individual or family problems and as necessary volunteers advice. Often she is the first professional person to come in contact with a family in which one of the members is in difficulty. Sometimes she is the one and only outsider to whom a confidence is entrusted.

Among the various members of a community with whom the nurse comes in contact is the mother of the family. The mother's influence is predominant in the family circle in the emotional and mental development of the child. Her influence begins during pregnancy when sensitivity is at a peak, when insecurity and anxiety can extend to the very first breath of the newborn. During pregnancy, biological processes can induce or stimulate the reappearance of former forgotten problems. For example, the relationships between a woman who is pregnant for the first time and her own mother may include misunderstandings that have never been cleared up. Pregnancy can bring to the surface personality weaknesses which could lead to emotional upsets. Former partially resolved problems suddenly come to life, mesh into the present situation and upset the pregnant woman if reassurance is not forthcoming. On the other hand, the revival of former conflicts can permit development towards true maturity or, if poorly acknowledged and accepted, can end in an abnormal attitude towards the unborn baby — unconscious rejection.

The varying moods common to expectant mothers require the nurse's understanding. She is the ideal one to help since her relationship with the mother is a very close one. She is accepted into the immediate family circle; she visits regularly during the course of the pregnancy, throughout the postpartum period and then according to the needs of the family.

In Great Britain and some other countries the nurse is called "Sister" with good reason. It is a symbolic term, where traditionally, the experienced, helpful nurse is looked upon as an elder sister. The nurse provides moral and professional support. She is sympathetic, understanding and interested. She accepts the mother as she is with her fears, her phobias and her idiosyncrasies. She explains, guides and enlists all available means of ad-

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Miss Loriot, who has had special preparation in psychiatric nursing, wrote this article while she was a student at the School of Public Health, University of Montreal.

ditional support and affection for the mother. It has been said that the pregnant woman needs more affection in the same way that she requires additional vitamins and protein. This is particularly true in the latter stages of pregnancy. It is also recognized that the maternal instinct develops in proportion to the amount of attention and sympathy lavished upon the mother. Husband and family need intelligent guidance during this period. They need help in knowing what attitude to take; what the possible variations in the mother's moods may be and the inevitable reactions characteristic of pregnancy. Ignorance, fear, uncertainty and anxiety readily dissolve in the light of knowledge. Objective, frank discussion during a period of crisis induces return to normality.

Another person in similar physiological circumstances whom the nurse can help, encourage and guide towards social rehabilitation is the unmarried mother. The customs of modern occidental society have created the tendency to hide, either within the family or in special institutions, the birth of a baby who does not have a legal father. Very often the visiting nurse is the first person to whom the secret is confessed. The young girl herself tries to hide her condition for as long as possible and thus does not receive adequate medical supervision. The nurse can help to formulate a realistic plan in such situations. She can persuade the parents to face the facts. Maternity care must be decided upon. Often a private hospital is desired. Community resources such as adoption agencies and foster homes must be investigated. The extent to which the parents can contribute financial support and ensure security for the young woman must be determined. The agencies able to assist in her rehabilitation must be considered. All these factors form essential parts of this particular situation in our society.

The aging population is increasing year by year. Social legislation tends to lag behind the rapid progress of this era, consequently the problems of the aged are becoming progressively more complex. For instance, the retirement age is more or less fixed at 60-65 years. Too little attention is paid to whether or not the individual is capable of productive, profitable work at the level of his mental and physical capacities. Generally speaking, the 65-year-old man who must retire from active life to leave room for the younger men can be more adequately prepared technically. If his retirement has not been planned for, there is little left for him to do except to sit in his rocking chair by the fire. People who are still physically and intellectually alert at retirement age feel frustrated, humiliated and helpless. Left to themselves day after day, often with only a meagre pension after being accustomed to comfortable living, some of them become depressed and deteriorate very rapidly. The most tragic aspect is their tendency to feel that they are in the way; that they are not wanted; that no one understands them. This state of mind can cause anxieties, frustrations and misunderstandings with their associates.

The very elderly who are showing progressive signs of senility are sometimes sources of friction in families forced to live in crowded quarters. People are not always informed about the signs of degeneration that fall to the lot of the elderly. The aged, no longer like their former selves, cannot understand why their diet and way of living must be regulated. Loss of memory, one of the symptoms of regression, leads to forgetfulness of recent events while memories of earlier days fill their thoughts and create a special world for them that others often fail to understand. Their behavior is childlike and they must be watched over, guided and assisted in every way.

The intelligent nurse who is well-informed concerning local resources, will know how to go about encouraging and cheering up the elderly person and his family. She will be able to suggest agencies concerned particularly in developing new interests for retired persons. They are given opportunities to participate in work projects in keeping with their abilities and desires. Their leisure time is organized and social gatherings with others having similar interests are planned. For those who cannot be cared for at home, there are institutions housing persons of the same age level with similar problems. In these homes, although there could often be better organization of leisure

time and activities, the old people feel peacefully settled, surrounded by their own belongings and with their memories. A great deal more remains to be done in the fields of gerontology and geriatrics however, apart from consideration of mental aspects of the aging process. Medical supervision and nursing service in these institutions should be provided by a permanent, competent staff consisting of, at least, a doctor and a resident nurse.

The convalescent group and handicapped individuals who may have had a more or less prolonged period of hospitalization, are very often prey to emotional upsets. The duration and demands of convalescence; the degree and anticipated length of time of invalidism; the chances of cure; the difficulties inherent in rehabilitation — all of these factors are disturbing and present financial problems.

The nurse functions, as a rule, to support and protect emotional equilibrium; to aid in rehabilitation and to organize and carry out necessary nursing care. She must be alert to poor familial or social adjustment: to the appearance of neuroses or psychoses. In particular, she must be able to analyze a situation, form an opinion and refer to other sources of aid at the right time.

In our schools we find the personnel who are entrusted with the teaching program and with maintenance. Here, more than anywhere else, preventive measures against physical and mental illness seem to be more highly organized and faithfully carried out. With the cooperation of parents, administrative authorities and teaching personnel, a plan for the application and supervision of preventive and corrective measures can function full-time. Through screening, personality and behavior problems come to the attention of specialists. Segregation and guidance of the less-gifted and the mentally deficient are carried out systematically along approved scientific lines. The more-gifted, perhaps, form the group who still lack adequate supervision.

The function of the nurse within the educational setting is more complex. She acts as liaison between pupils, parents, administration, attending physicians, community agencies, clinics, hospitals, outpatient departments, dentists, social service, and even juvenile courts and correctional agencies. Fortunately, the latter relationship is a rarity.

Finally, there are the individuals including children who are presently under psychiatric care or who have been under it. They require long-term supervision and extensive social rehabilitation. In this instance, the nurse's main role, in addition to intelligent observation, will consist of keeping the doctor informed about the patient's condition and of instruction to the family concerning the nature of such illness. Sometimes the patient himself requires teaching, if he is capable of understanding and making his own decisions.

Another group of individuals encountered will be those who are acutely ill mentally. They need to have treatment as quickly as possible in order to prevent their present condition becoming worse and to offset a chronic state. Sometimes treatment in the doctor's office is enough. Others will require placement in psychiatric institutions and hospitalization for varying lengths of time.

Those who have returned home after treatment in a psychiatric hospital may tend to feel rather uneasy in the family circle. Despite the good will of all other members of the family, it is not unusual to find such a patient keeping to himself. If the visiting nurse knows in advance that a psychiatric patient is being discharged, she can visit the family before the patient returns home and help prepare them so that the adjustment process for everyone is speeded up.

Conclusion

It is evident that, for the public health nurse to provide services of this calibre, she has to have a good background of knowledge in psychology, psychiatry and sociology. She must know how to recognize normal behavior. She must understand the reactions of individuals to illness; to serious problems. She must be aware of the way in which some people will use their emotions, either to advantage or disadvantage, in reaching an adjustment. Understanding and accurate interpretation of the behavior of others

helps the nurse to meet their needs adequately. Her knowledge of applied psychology will make it possible for her to use special interviewing techniques. She, herself, must have emotional stability and be able to use her innate qualities of tact, objective observation, intuition, sympathy and understanding to best advantage. Development of these natural gifts will help her in making mental health an integral part of her daily work.

HYALINE MEMBRANE DISEASE

Elda Y. Dunham

Hyaline membrane disease is the number one killer of premature infants.

Occurring in 20 per cent of all premature births, hyaline membrane disease accounts for 40 per cent of the deaths in the neonatal period. Infants born by Caesarean section are also prone to the development of the disease, as well as those born of diabetic mothers and of mothers with obstetrical complications such as toxemia, placenta previa and accidental hemorrhage. It is seldom seen, however, in the full-term infant of a normal vaginal delivery.

One in a whole family of respiratory distress syndromes, this condition is characterized by a glassy, hyaline-type membrane that lines the alveolar ducts, blocking them off and thus preventing adequate exchange of gases between the alveoli and capillaries. Some vaguely-understood physiological disturbance produces, among other things, a chemical imbalance in the blood; because of this chemical imbalance and perhaps due to injury or immaturity of the capillaries, a high-protein fluid seeps through their walls into the surrounding lung tissue and alveoli. An earlier theory had the membrane formed from aspirated amniotic fluid and its contents — blood, vernix and meconium. Although there is a similar form of respiratory distress caused by these factors, it is now widely accepted that hyaline membrane disease is a distinctly separate condition.

Miss Dunham is presently engaged in tuberculosis survey work, in the province of Ontario with the National Sanitorium Association.

Clinical Picture

The infant usually breathes well and cries vigorously at birth; his color is often pink, air entry into the lungs is good, and the heart sounds are loud. Edema of the extremities may be present to a greater degree than in the average premature.

One-half to two hours after birth, the respirations may become rapid and labored with chest retraction. This retraction or indrawing may appear in the sternal, subcostal or intercostal regions, or the whole chest wall may be sucked inwards with each inspiration. Accompanying this is a moaning or grunting sound on expiration. These two symptoms — indrawing and grunting — indicate stiff lungs, probably caused by pulmonary edema as well as the forming membrane. Auscultation of the chest reveals a decreased air entry. A chest x-ray taken at this point shows a fine granular pattern distributed evenly throughout both lung fields.

The rate of progress of the symptoms depends upon the severity of the disease, but the general picture is one extending over some 40 to 60 hours. After the first 12 hours the symptoms may slowly subside — or they may progress. In the latter case, the respirations become more rapid, perhaps somewhat irregular, and extremely embarrassed, accompanied by flaring of the nostrils. Respiratory indrawing and grunting become markedly pronounced. The color may be pale or cyanotic though more often it remains remarkably pink until almost the height of the disease when there will be severe

cyanosis, a greyish pallor or a combination of both in the form of peripheral mottling. When disturbed, the child grimaces and emits an irritable whining cry. Otherwise, he lies limp and expressionless, as though the increased work of breathing utilizes every ounce of energy he has. Edema increases as excess proteins seep through the capillary walls into the surrounding tissues of the limbs, buttocks and face. Not only may râles be heard on auscultation of the chest, but also the heart sounds may be somewhat muffled. Again x-rayed, the lung will have changed appearance. Now, a uniform mottled pattern is present as small areas of the lobes are collapsed and become solidified. A secondary atelectasis has developed.

Poor Prognostic Signs

In this highly unpredictable disease the prognosis is guarded, but one always entertains a hope that an hour's time will show some improvement in the condition of the infant. However, there are several poor prognostic signs that must be watched for. When one or any combination of these signs — indicating exhaustion, heart failure, circulatory failure, or shock — present themselves, hope fades. They are: a sudden rise in the respiratory rate, a slowing heart rate, a drop in body temperature, cyanosis not relieved by oxygen, periods of apnea, the formation of sclerema, and unresponsiveness.

As the infant strives harder to meet his bodily needs for oxygen and rid himself of excess carbon dioxide, exhaustion overcomes him; he has a period of apnea with cyanosis. Spontaneously or with help he may rally, but these attacks continue; his respirations gradually become slower and more shallow and eventually he dies due to failure of blood-gas homeostasis. Twenty to 30 per cent of these infants die. Death occurs seldom before six hours, most frequently between six and 24 hours, and rarely after 60 hours.

Post-mortem examination reveals a severe pulmonary congestion, a secondary atelectasis, and the presence of a hyaline-type membrane lining the alveolar ducts.

Treatment and Nursing Care

One of the most important functions of the nurse is observation. Early recognition with prompt and accurate reporting of the signs are most helpful to the doctor in treating them. Another important nursing function is careful control of the infant's environment. The infant should be placed in an incubator that will maintain a definite temperature, humidity, and oxygen content without fluctuation. It is generally agreed that the incubator temperature should be regulated to maintain the infant's body temperature at 97°-98°. In order to do this the probable incubator temperature will be 85°-90°. However, in some centres it is felt that hypothermia may aid the infant's breathing by lowering his basal metabolism and decreasing his need for oxygen. The latter form of treatment is probably not as widely employed as is the former. In either case, the temperature should be checked every three to four hours and kept at the desired level.

A high humidity within the incubator is important for several reasons:

1. There is less body heat loss by evaporation in a humid atmosphere.
2. It helps to soften and loosen mucus and sticky secretions which may have collected in the air passages.
3. Humidity may help to keep the forming membrane pliable and penetrable by oxygen and carbon dioxide.

Respirations appear easier when an infant is moved from a dry to a moist environment. Supersaturation of the air is sometimes effected by means of a vaporizer. However, recent studies have found this to be of doubtful value to the infant. Oxygen may be given at low rates of flow, and if found to benefit the child in any way, it may be maintained at 35-40 per cent concentration. It should never be administered at a higher concentration unless indicated by cyanosis. An oxygen analyzer is always employed to measure the concentration every two to four hours.

Everything possible must be done to aid the breathing. The baby must not be hindered by clothing, positioning, or any obstruction in the nasopharynx. Great care must be taken to maintain the airway clear of mucus and fluid. Withdrawal of the stomach contents gives the assurance that regurgitation and aspiration into the lungs will not

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take place. Following this the infant may be placed in Trendelenberg position to aid in draining secretions from the lungs and air passages. This position may not be advisable for long, however, as the weight of the stomach contents thrown upward on the diaphragm could hamper the already-embarrassed efforts at respiration. On the other hand, should this position or any other position be found to aid the severe dyspnea, by all means keep him in that position as much as possible. By turning the child from side to side frequently and aspirating any secretions by means of gentle suction, the nurse is doing her utmost to maintain a clear airway and to provide and maintain good expansion of the lungs.

Changes in rate, rhythm, and depth of the respirations, as well as changes in color, activity and response must be noted carefully and reported promptly.

Drugs

There are several routine and emergency drugs that may be given in this disease. The first of these, given routinely, are antibiotics; these are administered in large doses as a prophylactic measure against secondary infections, the drugs of choice being chloromycetin and penicillin-streptomycin compounds. The second commonly used drug is digoxin, given to strengthen and stabilize the action of the heart. Some centres feel that it should be given as a matter of routine in severe cases, rather than only in those cases which have developed heart failure.

Emergency drugs such as caffeine and coramine are very little use in this condition. If apnea is not relieved by manual stimulation, caffeine can be employed. The usual 7½ grain ampoules are given at a dosage of one minim per pound of body weight up to a maximum of four minims. However, at this point, the time taken to prepare the injection would probably be better spent applying resuscitation by means of positive-negative pressure at a force no greater than 30 cubic centimeters of water.

Feeding

Since there is danger of regurgitation, vomiting and aspiration, there is a tendency to withhold oral feedings for periods up to 60 hours. Moreover, edema being present, there is also a contraindication to the use of hypodermoclysis. If, on the other hand, the infant becomes dehydrated before oral feedings are felt advisable, then hypodermoclysis could be employed. Early intravenous fluids are frequently administered as a means of balancing the blood chemistry in hope of arresting the progress of the disease.

Summary

Hyaline membrane disease causes 40 per cent of all premature neonatal deaths. It is a form of respiratory distress wherein a hyaline-type membrane lines and plugs the alveolar ducts and prevents adequate exchange of gases. As yet the exact cause of the disease is unknown but the offending membrane originates in a high-protein exudate from the capillaries. Onset takes place shortly after birth, the first symptoms being respiratory indrawing and grunting and perhaps edema of the limbs. Color may be cyanotic but more frequently it remains good until late in the progress of the disease. As the symptoms become more severe, keen observation will reveal signs of exhaustion, heart failure, circulatory failure and shock. Death occurs in 20 to 30 per cent of those affected, usually between six and 48 hours of life. Diagnosis is made by x-ray which reveals a typical, uniform, granular pattern followed by a mottled appearance and finally by solidification of the entire lung; this last of course is found on post-mortem. Treatment includes careful observation by experienced persons, warmth, humidity, and oxygen as well as the administration of prophylactic antibiotics. As yet there is no known specific life-saving treatment available for these infants, although much research is presently being carried out. The only known prevention is normal vaginal delivery at term.

Absence of occupation is not rest,
A mind quite vacant is a mind distress'd.
— COWPER

Oh, the saddest of sights in a world of sin
Is a little lost pup with his tail tucked in!
— ARTHUR GUITERMAN



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In Memoriam

Margaret Helen (Murray) Cameron who graduated from the Vancouver General Hospital in 1916, died early this year in California.

* * *

Frances A. Graham, a nurse in the Spanish-American war of 1898, died in Vancouver early this year. She was 94 years of age.

* * *

Irene LeBel, a graduate of Hôpital de la Miséricorde, Montreal in 1934, died on April 4, 1960. For 23 years she gave outstanding service in outpost areas of the province of Quebec.

* * *

Katharine Margaret MacMillan, a nursing sister in World War I, died in Vancouver on April 3, 1960.

* * *

Audrey V. McClymont who was a head nurse at the Woodlands School for retarded children in New Westminster, B.C. died in a highway accident April 17, 1960.

* * *

Rosaline Maillet, a graduate of Hotel Dieu Hospital, Moncton, died in a car accident on April 17, 1960. She had been engaged in public health nursing in New Brunswick.

* * *

Amy (Pollard) Morford, an 1891 graduate of the Mack Training School for Nurses, St. Catharines, Ont. died in New York City on March 5, 1960. Prior to her marriage she organized the first school for nurses in St. Thomas, Ont. She maintained an active interest in her own school throughout the years and was able to be present for its 75th anniversary in 1949.

* * *

Glory B. Morrison who graduated from the King Edward Memorial Hospital, Hamilton, Bermuda in 1923 died in Toronto on March 16, 1960. During her professional career she had nursed in Bermuda, Newmarket, Ont., Toronto, Vancouver and New York.

* * *

Gwen Nash, a graduate of the University College Hospital, London, England in 1950 died in a car accident near Sydney, N.S. on April 17, 1960. She had been engaged in public health nursing in New Brunswick.

* * *

Myrtle (Lawson) Sansone who graduated from St. Joseph's Hospital, London, Ont. in 1923 died on March 17, 1960. For several years she was on the staff of Ford Hospital, Detroit.

* * *

Doreen (Clifford) Saunders, a 1952 graduate of Ottawa Civic Hospital died suddenly on February 23, 1960. She had been on the staff of the hospital until her marriage.

* * *

Edith Tye, who graduated from The Amasa Wood Hospital, St. Thomas, Ont. in 1904 died in December, 1959. She had been active in her profession for over 50 years.

* * *

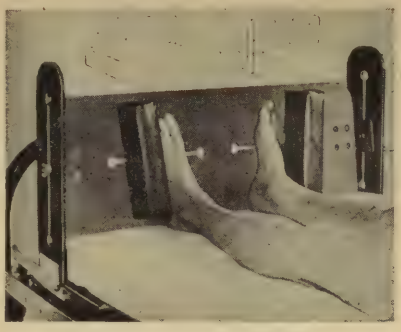
Ivy M. Weston who graduated from the Grey Nuns' Hospital, Regina in 1922, died on April 29, 1960. She had been engaged in nursing in New York City.

Adults want to discern some relevance in what they study. They do not easily submit to shabby, threadbare lectures. The adult wants to participate, to try out ideas, to test hypotheses, to judge and dissent. He is not anxious to memorize some code of truth. He feels with Sam Slick; "You may stop a man's mouth by crammin' a book down his throat, but you won't convince him." What he wants most are experiences to be tasted and tested. There is a place for honest difference of opinion, for the free and fair engagement in controversy, and it is to be hoped that . . . ample provision will be made for it. — Dr. J. Roby Kidd

A special committee of the Nursing Education Alumnae Association of Teachers College, Columbia University, is taking steps to establish an endowed research professorship in nursing and nursing education. The professorship will be in honor of the contribution of Miss **Isobel Maitland Stewart,** Professor Emeritus of Nursing Education at T.C. The proposed professorship will be the first to honor a living T.C. professor and will make possible continuing research in nursing and nursing education. *T.C. Topics,* Spring, 1960

* * *

Those who cannot remember the past are condemned to repeat it. — Santayana



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Book Reviews

Mayes' Handbook for Midwives and Maternity Nurses. Revised by F. D. Thomas, S.R.N., S.C.M. 476 pages. The Macmillan Company of Canada Limited, 70 Bond St., Toronto. 6th ed. 1959. Price $3.85.

Reviewed by Mrs. T. Beveridge, Box 9600, Selkirk, Manitoba.

This text requires little introduction to Canadian nurses. Although primarily directed towards candidates for certification by the British Central Midwives Board, it has achieved a place on the bookshelf of the well-read nurse in this country.

This recently revised edition lives up fully to the expectations of those who are familiar with earlier versions. In addition to being more up-to-date, the subject matter has been expanded and streamlined to include a comprehensive coverage of both normal and abnormal obstetrics, analgesia in childbirth, relaxation and exercises, abnormalities of the infant, and a short history of midwifery.

The chapters on domiciliary midwifery and Government services, while interesting, are superfluous for the Canadian nurse.

A particularly pleasing feature is the inclusion, at the end of each chapter, of a short list of questions. They serve to emphasize important points discussed as well as affording an excellent means of review.

This book is highly recommended to Canadian nurses, particularly those who intend to specialize in the field of obstetrics, as it combines accuracy with a superb clarity of presentation, both in text and in illustration.

Nursing of Children by Robert A. Lyon, M.D. and Elgie M. Wallinger, R.N., B.S., M.A. 554 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 5th ed. 1959. Price $5.00.

Reviewed by Mrs. A. Game, Clinical Instructor, The Children's Hospital, Winnipeg.

The present revision has taken into account the general trend toward emphasizing that a knowledge of normal growth and development and of nutritional patterns is essential when caring for children. Upon this basic foundation the care of the sick child has been built.

The material has been expressed clearly and has been arranged in six units. The first two discuss the normal growth and development and nutritional requirements of the healthy child. Unit three is a new addition and deals with the well child. Units four and five are devoted to the child in hospital and to childhood diseases — diagnosis, treatment, nursing care and prevention. The last unit describes the institutions and organizations outside of the hospital

which offer services to special groups of children.

The text is well illustrated. Headings and sub-headings provide easy identification of subject material. Reference lists at the end of each unit are adequate and up-to-date. Throughout the book there is a constant reminder for the nurse that she is replacing "the parent in supplying security and love which the child needs for a rapid and complete recovery."

This text should be an excellent reference for student nurse and of great value to the instructor.

Surgery for Nurses by James Moroney, M.B., Ch.B., F.R.C.S. (Eng.), L.R.C.P. (Lond.). 751 pages. The Macmillan Company of Canada Limited, 70 Bond Street, Toronto. 6th ed. 1959. Price $5.00.

Reviewed by Miss Marie Swarychewski, St. Rita Hospital, Sydney, N.S.

The illustrations in the book are exceptionally good, the subject material is well presented. Explanations are brief and very clear. The many "whys" are answered adequately in each chapter. As with all texts there may be some differences of opinion regarding techniques and procedures. I would strongly recommend this book as a good surgical nursing reference.

Obstetric and Gynecologic Milestones by Harold Speert, M.D. 700 pages. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ont. 1958. Price $15.00.

Reviewed by Miss Gertrude Yeats, Kingston, Ontario.

This book gives a concise picture of the great men in medical history and deals particularly with the development of obstetrics and gynecology. Eponymic nomenclature, long familiar to us but often not fully understood as to its origin, comes to life as the author relates the stories of the men whose names have become inseparably linked with equipment, procedures and so forth, for example Piper forceps, Braxton Hicks sign.

Instructors will find excellent resource material for teaching anatomy, obstetrics, gynecology and history of nursing.

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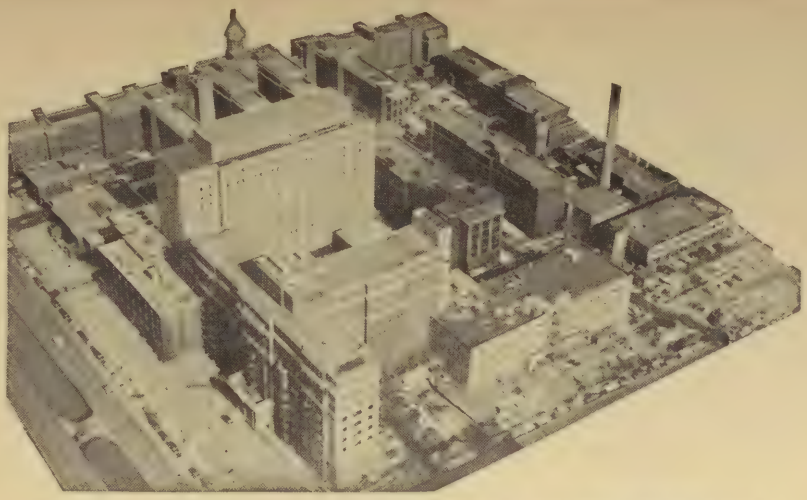
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Registered General Staff Nurses for all services, R.N.A.O. salary schedule, increments every 6-mo. 40-hr. wk., differential for evening & night duty. Excellent personnel policies & pension plan. Apply to the: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

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General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing. Douglas Memorial Hospital. Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital. Tillsonburg, Ontario.

Public Health Nurses qualified for generalized program. Minimum salary $3,500 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, **Fort William & District Health Unit,** 900 Arthur Street, Fort William, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurse & Certified Nursing Assistants for 100-bed General Hospital attractive town in vacation resort area on Lake Huron. Good personnel policies, residence accommodation available. Apply to: Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurses (qualified). Generalized program includes some bedside nursing. Salary $3,200-$4,250, annual increment $150, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses (qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,750; starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr., pension plan, P.S.I. & Blue Cross benefits. Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Road, Etobicoke, Ontario.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

DIRECTOR OF NURSING

General Hospital of 109 beds, located in Northwestern B.C.
requires Director of Nursing.
Salary is open and dependent on qualifications and experience.
Residence accommodation available if desired.

Apply giving full particulars of education and experience to:
ADMINISTRATOR, PRINCE RUPERT GENERAL HOSPITAL, PRINCE RUPERT, B.C.

VICTORIAN ORDER OF NURSES FOR CANADA
has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

- Opportunity for promotion.
- Transportation while on duty.
- Vacation with pay.
- Retirement annuity benefits.

For further information write to:
Director in Chief,
Victorian Order of Nurses for Canada
5 Blackburn Ave., Ottawa 2, Ontario

2 INSTRUCTORS

Certificate in Nursing Education required - One to teach basic Science - Student enrollment 70-80 - One class per year, registers in September - Well equipped modern School & Residence

ASSISTANT DIRECTOR NURSING SERVICE - EVENING OR NIGHT PERIOD

Previous supervisory experience required. Certificate in Nursing Service Administration desirable.

200-bed hospital - fully accredited. Pleasant city 38,000 close to larger centres. Good salary & personnel policies. Additional salary for advanced preparation above positions. *For further details apply to:*

THE DIRECTOR OF NURSING, GENERAL HOSPITAL, GUELPH, ONTARIO

Public Health Nurses for generalized program with City of Chatham, minimum salary $3,500 — 5-day wk., annual increments, 4-wk. vacation, pension plan, Windsor medical & hospitalization plan, car allowance (monthly) & sick leave, consideration given for experience. Apply to: Miss M. Mackenzie, Supervisor of Nurses, P.O. Box 787, Chatham, Ont.

Public Health Nurse for generalized program. Salary $3,500 - $4,375 over a 5 year period, pension plan, P.S.I. Apply: Mr. D. T. McLeod, Secretary-Treasurer, District of Kenora Health Unit, Box 174, Kenora, Ontario.

Public Health Nurses (Qualified) required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurse for September 1960 (Preston Board of Health). For further information write: Mrs. Bertha M. Young, Health Centre, 566 Duke Street, Preston, Ontario.

Public Health Nurses for generalized nursing program. Salary range $3,500-$4,400, annual increment $150, salary based on experience. 5-day wk., vacation 4-wks., pension plan & P.S.I. available. Car allowance or transportation provided. Apply to: Director, St. Catharines-Lincoln Health Unit, St. Catharines, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, hospital plan, hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½-days monthly, vacation 4-wks. a year, allowance for use of own car. Salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J. R. Mayers, M.O.H & Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Public Health Nurses for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500-$4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave - 1½ days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Uniform allowance - Initial $200, yearly $75. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (2) Bilingual for generalized public health nursing service; maternal & child health, tuberculosis, school health etc. Salary $3,500 - $4,500 annually; annual increment $200. Hospital plan, P.S.I., pension plan, sick leave- 1½-days monthly, accumulative. Vacation - 4-wk. yearly. Transportation provided or allowance for use of private car. Apply to: Dr. J. B. Cook, M.O.H. & Director, Sudbury & District Health Unit, Sudbury, Ontario.

Public Health Nurses (Qualified) for Victorian Order of Nurses (Toronto Branch). Minimum salary $3,600, consideration given to past experience. Annual increments, 5-day wk., 4-wk. vacation. $100 uniform allowance. P.S.I. & Supplementary Blue Cross available, pension plan benefits. Apply: Director, 281 Sherbourne Street, Toronto 2, Ontario. WA. 1-3184

Public Health Nurses for Staff positions. Starting salary $3,600 with uniform allowance & annual increments. Good personnel policies. Apply to: Miss Helen Saunders, Director, Victorian Order of Nurses, Windsor, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Nurses (Bilingual) having a public health certificate for a Health Unit in rural Ontario. Minimum salary $3,300, 5-day wk., cars available or allowance for own car. Cumulative sick leave. For further information write to: Dr. R. G. Grenon, Director, Prescott & Russell Health Unit, Hawkesbury, Ontario.

Registered Nurse to take charge of new operating room — also **General Duty Nurses** for modern 55-bed hospital, situated in Bruce County, town of 3,000 people, on the shores of Lake Huron. Accommodation available in nurses' residence. Excellent recreational facilities, & all churches represented. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

Operating Room Supervisor for 250-bed hospital. Postgraduate study required. Good salary & personnel policies. Apply: Director of Nursing, Grace Hospital, Windsor, Ontario.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Matron (preferably bilingual) for July for newly constructed modern 23-bed General Hospital located at Murdochville. Duties to include supervision of personnel & general hospital maintenance. Excellent recreation facilities including indoor swimming & artificial ice. Three (3) churches. Reply stating age, experience & training to Box No. L, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic, Northwest Territories and the Yukon Territory.

SALARIES



(1) Public Health Nursing Supervisors: up to $5,460 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $5,400 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $4,050 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

- Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three week's annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.
- Special pay and leave allowances for those posted to isolated areas.

For interesting challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Director of Nursing for modern non-profit, J.C.A.H. Accredited 125-bed General Hospital. Downriver area, Detroit, Michigan. $8,000 - $10,000 yearly, depending on qualifications. Liberal personnel policies, unusual opportunity. Approved residency program; staff, board certified specialists. Progressive expanding organization. Emphasis on postgraduate education. Experience in Nursing Service, Supervision & Administration preferred; Master's or Bachelor's Degree required. Forward complete details to Box K, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Matron (1) for 17-bed hospital situated in southern Saskatchewan, only 20-mi. from U.S.A. Starting salary $340 per mo. with increments every 6-mo., 40-hr. wk. & 3-wk. vacation with pay. Applicants should be 30 years of age & have Supervisory experience. If interested, please write to: Mrs. B. McClement (Matron) or Mr. I. Antonichuk (Manager) at Bienfait Coalfields Union Hospital, Bienfait, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Registered Nurses immediately (2) for 50-bed hospital. Salary $275 per mo., 40-hr. wk., no split shifts. $10 extra for night shift, comfortable residence. Good location with excellent bus & rail service. Apply to: Matron, Union Hospital, Rosetown, Saskatchewan.

Graduate Nurse (1) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 40-hr. work wk., 3-wk. vacation, plus statutory holidays. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn., O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses for Operating Room, Delivery, Nursery — all shifts. Starting salary $340 per mo., liberal shift differential, 9 paid holidays, insurance, sick leave & vacation. Contact: Director of Nurses, Washington Township Hospital, 2000 Mowry Avenue, Fremont, California.

Registered General Duty Nurses (2) for small General Hospital. Salary $375 per month. For information write: Box 336, Dos Palos, California or phone Express 2-3266 collect.

General Duty Nurses for large teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2 California.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

REGISTERED NURSES

required

OBSTETRICS

AND

OPERATING ROOM

Good personnel policies

Pension plan & group insurance

Apply:

DIRECTOR OF NURSING
QUEENSWAY GENERAL HOSPITAL
TORONTO 18, ONTARIO

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Operating Room Nurses: Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (1/2) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Monthly salary rates: $370-$400 days; & $400-$430 afternoon & nights, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $450 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80) bi-weekly until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

ENGLAND

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127-Plastic Surgery, 50-Orthopedic beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses commences October 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national nurses' salary paid. Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting 2 references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

ALBERTA

Nurses for General Duty (2) in 29-bed hospital near summer resort. Salary $270 per mo. Excellent residence. Apply: Matron, Municipal Hospital, Eckville, Alberta.

Science & Clinical Instructor for school of nursing, one (1) class yearly. Registered Nurses for General Duty. Apply to: Director of Nursing, St. Joseph's General Hospital, Vegreville, Alberta.

BRITISH COLUMBIA

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

MANITOBA

Registered Nurses (2) for small modern hospital situated in the Whiteshell district of Manitoba. Excellent bus & train services to Winnipeg & Kenora. **One (1) Registered Nurse preferably with O.R. experience.** Starting salary $295 with semi-annual increases of $5.00, 1-mo. vacation after 1-yr., 8-statutory holidays. Apply: Matron, District Hospital, Whitemouth, Manitoba.

ONTARIO

Director of Nursing & Assistant to Administrator — for 60-bed hospital serving 12,000 area Central Ontario. Here is an opportunity for a qualified nursing administrator to widen her field into full administration in hospital in small town. Studies under way for expansion of services & rebuilding. In application give experience, salary requirements & date of commencement, in confidence, to the Secretary of the Board, Willett Hospital, Paris, Ontario.

Supervisor of Nursing for modern 42-bed hospital. Residence accommodation available. State experience & salary requested. Direct enquiries to: The Administrator, General Hospital, P.O. Box 909, Sioux Lookout, Ontario.

Instructor for Certified Nursing Assistant Course. Training program is 10-months. 100-bed modern hospital. **Dietitian** for 100-bed modern hospital. Excellent personnel policies & salary scale, pension plan. **Physiotherapist** for 100-bed modern hospital. Duties to commence September 1, 1960. Apply to: Sister Superior, St. Vincent de Paul Hospital, Brockville, Ontario.

Instructor in July to organize & teach new C.N.A. Course commencing September, 5-day 40-hr. wk., residence available. Apply: Director of Nursing, St. Andrews Hospital, Midland, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Duties to commence in July, 1960. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

QUEBEC

General Duty Nurse for new modern 24-bed hospital located in centre of Gaspe Peninsula to be opened in August. Working conditions in accordance with Quebec Association of Nurses standards. 44-hr. wk., excellent recreation facilities including indoor swimming & artificial ice. Reply stating training & experience to Box L, the Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Registered Laboratory Technician for new modern 24-bed hospital located in centre of Gaspe Peninsula, excellent recreation facilities including indoor swimming & artificial ice. Salary commensurate with qualifications. Reply stating training & experience to: Box L, The Canadian Nurse Journal, 1522 Sherbrooke Street west, Montreal 25, Quebec.

SASKATCHEWAN

General Duty Nurses for 14-bed Elrose Union Hospital. Salary $280 with yearly increments full maintenance in residence for $34.50, 40-hr. wk. Apply: J. V. Nouch, Elrose, Saskatchewan.

NOTRE DAME HOSPITAL OF MONTREAL

NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years. Pension Fund.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 2; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

JEWISH GENERAL HOSPITAL

MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Residence accommodation available.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

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Advertising Manager, Ruth H. Baumel, The Canadian Nurse Journal

1522 Sherbrooke Street West, Montreal 25, Quebec.

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Editorial Advisors: Alberta, Miss Irene M. Robertson, 11831-87th Ave., Edmonton; **British Columbia,** Miss Marion E. Macdonell, 1807 W. 36th Ave., Vancouver 13; **Manitoba,** Miss Sheila L. Nixon, 25 Langside St., Winnipeg; **New Brunswick,** Miss Shirley Y. Alcoe, 180 Charlotte St., Fredericton; **Newfoundland,** Miss Isabel Sutton, 66a Mullock St., St. John's; **Nova Scotia,** Mrs. Hope Mack, Nova Scotia Sanatorium, Kentville; **Ontario,** Miss Jean Watt, R.N.A.O., 33 Price St., Toronto; **Prince Edward Island,** Sr. M. David, Charlottetown Hospital; **Quebec,** Miss Geneviève Lamarre, Hôpital de l'Enfant Jésus, Quebec City (French), Sr. M. Assumpta, St. Mary's Hospital, Montreal (English); **Saskatchewan,** Miss Victoria Antonini, S.R.N.A., 2066 Retallack St., Regina.

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The views expressed in the various articles are the views of the authors and do not necessarily represent the policy or views of The Canadian Nurse *nor of the Canadian Nurses' Association.*

Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
In combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four week's notice and the *old* address as well as the new are necessary.
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Authorized as Second-Class Mail, Post Office Department, Ottawa.
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Between Ourselves

We are particularly happy that we are able to share with all of you the excellent summary of the outstanding achievements of our national association during the past biennium that was presented by PRESIDENT ALICE GIRARD at the recent convention. We admire the restraint with which Miss Girard noted the various developments but refrained from elaborating on them lest she encroach upon the rights of those who had been directly responsible for the work.

It was with considerable trepidation that Miss Girard assumed the responsibilities of president in June 1958. She was the first nurse whose native language was French to be elected to this position. Because she is completely bilingual, language was no problem, but she realized that always, when a "first" is being tested, she must not spare herself in any way. It is very much to her credit that despite an exceedingly heavy work load at Hôpital St. Luc, where she is both assistant administrator and director of nursing, Miss Girard has unfalteringly demonstrated her abilities as a true leader. Her colleagues, both English and French alike, congratulate her on a task well done and wish her great success in all future undertakings.

* * *

Several elements are of prime importance in an operating theatre to ensure an environment that will be safe for the patients and at the same time promote the greatest efficiency of every member of the surgical team. SISTER MARIE PLACIDE gives warning of disasters that may occur in her "Fire and Explosion in the O.R." Responsibility for the safety program is shared by all operating room personnel — doctors, nurses, technicians and aides. Each person should know how to use the fire extinguisher, how to report the fire, how to remove the patient and, equally important, how to write a report on what occurs.

One of the modern advances in surgery is the use of one of the hypothermia techniques — cooling the patient's body prior to the operation in an ice bath or by means of refrigeration blankets. DR. E. S. RUSSELL describes the technique as it is currently practised. DR. DONALD B. EFFLER also notes its use in his presentation. MISS BARBARA ROWLAND details the essential postoperative nursing care.

A few Canadian hospitals have organized courses for the training of a new category of worker — the operating room technician. MISS SUMI IWAMOTO tells us about the program that is functioning at the Toronto General Hospital.

If there are to be technicians who replace the scrub nurses in the operating theatres, what kind of experience is planned for student nurses? MISS AMY E. GRIFFIN made a searching study and evaluation of a period of experience in operating room work for her master's degree thesis. She has summarized her findings in her article. Because she felt some supervisors and instructors might wish to have access to the full study, Miss Griffin has sent us a copy of it which is available as a loan for a limited time. Write us if you wish to borrow it.

* * *

There is genuine concern among public health authorities over the steady increase in the incidence of **alcoholism.** The specific effect of alcohol is to inhibit the activity of those parts of the brain that control such functions as caution, self-control, judgment and prudence. When these centres fail to function, the result is undisciplined, childish behavior that accounts largely for the frequency of automobile accidents. There is no question that the *drunken* driver is a menace. The *drinking* driver may be even more dangerous because of the over-confidence, recklessness and self-assurance that alcohol may develop.

What is a nurse's responsibility in caring for an alcoholic patient? A group of student nurses at Toronto Western Hospital studied this question and has come up with some reasonable answers.

* * *

Reprints have been made up of the excellent article on Parkinson's Disease, written by DR. DAVID DEJONG, that was published last April. Though it was written primarily for nurses, the language is simple enough to explain a lot of things about this condition to a lay person. While the supply lasts, the reprints may be procured from the Journal office, 1522 Sherbrooke Street West, Montreal 25, Que. The price is ten cents each.

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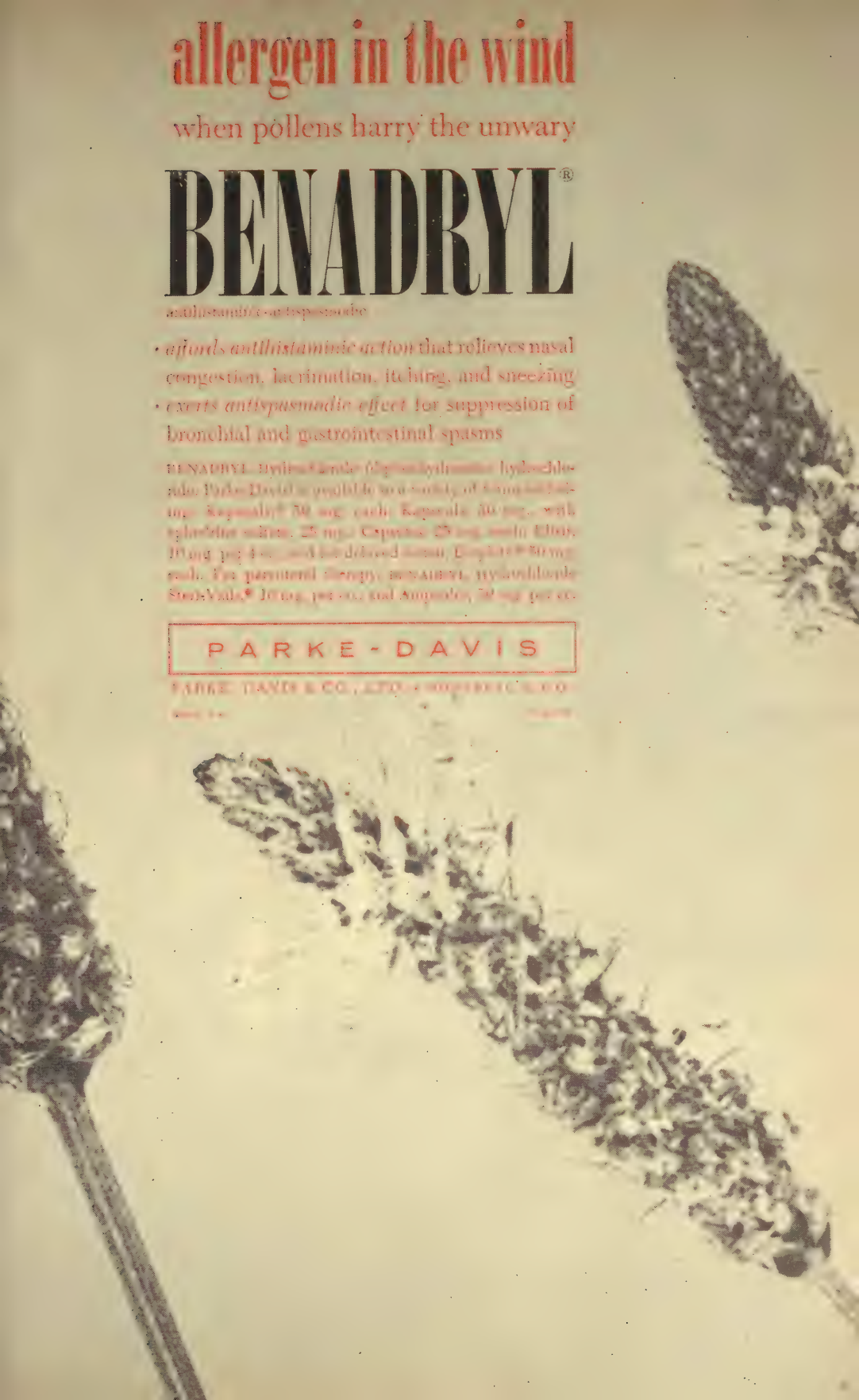
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Manufacturer—Bristol Laboratories of Canada Limited, 286 St. Paul St. West, Montreal.

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Random Comments

Dear Editor:

I should be grateful if you would permit me to express appreciation to the nursing staffs of the hospitals I visited during my 12-week tour of Canadian hospitals.

The value of my tour, to study nursing education, was enhanced by the generous giving of time and hospitality by hospitals in Windsor, Brantford, Hamilton, Toronto, Ottawa, Montreal and Sherbrooke. I have been impressed with the high standard of hospital design and equipment and some aspects of your nursing education programs.

When Canadian nurses are visiting England I should be happy to assist them in seeing our hospitals.

CLIFFORD SCOWCROFT,
Principal Tutor,
Pinderfields General Hospital,
Wakefield, England.

Dear Editor:

Our magazine gives me much pleasure and stimulation. I look forward to reading it every month. Being the head nurse in a private nursing home, I am especially interested in articles on geriatrics and public health. What a help the magazine is in my efforts to keep up with developments! My sincere thanks for it all.

EDITH MAYER, Ontario

Dear Editor:

May I take this opportunity to thank you and *The Canadian Nurse* for selecting my nursing care study as a winner of the Macmillan Award.

I am very pleased to be able to use a part of the award money to purchase a three-year subscription to your very worthwhile magazine.

Rosemarie Perka, Alberta

Dear Editor:

I just happened to glance through the May issue of *The Canadian Nurse* and I paused at Random Comments. The letter from S.O'D. New Brunswick particularly interested me. I agree with her sentiments. Any person who wishes extra care, TLC or company could hire a special nurse. To me, the amount of nursing care given to each patient should be in direct relation to the severity and nature of his illness. False, as the answer to question no. 4, implies that

a seriously ill poor patient should be neglected if a patient in a private ward desires a cup of tea. To me, this violates the basic tenets of nursing. I hope that this was not what the author had in mind and that the question was merely poorly phrased.

One question I did feel was poorly phrased was no. 45. Fundamental needs in sick and well persons include

(a) to feel useful
(b) to eliminate daily
(c) to be loved
(d) to be approved of

The only incorrect one is (b) to eliminate daily — to eliminate what? Feces is obviously what the author had in mind. But, is not urine eliminated from the body daily? If a patient does not void for 24 hours, is it not a cause for concern? In a test, I feel that it is unfair to use vague terms like "eliminate." If bowel movements are implied, why not use the term in the first place and avoid confusing some poor student (or me!)?

Well, you asked for some other readers' comments on the test questions in the January issue, so these are my views. I'm sure that you've received many other letters on this subject.

DORIS STYMEST, British Columbia

. . . butter was once a rarity to all but pharmacists and physicians. No man knows when or where butter-making began, but authorities guess that it started long before recorded history. Earliest historical references show that the people of India used butter in religious ceremonies around 2000 B.C. Ancient Hindu bridal feasts included milk, honey and butter; during the marriage ceremony the bride greased the axles of the bridal carriage with butter.

Early Romans used butter only as a cosmetic or medicine and considered the soot of burnt butter an ideal remedy for eye afflictions . . . Throughout the Middle Ages butter was a favorite ointment base. Only the very wealthy could afford it as food and it was always a mark of affluence though rarely eaten fresh. — *MD*

* * *

After we make our habits, they seem to start making us.

* * *

To be really intelligent, one must be as curious as a cat.

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SUPERINTENDENT OF NURSING,
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HAMILTON, ONTARIO

A childhood dream may still be the first step in the development of the potential nurse.

I decided to be a nurse at the age of six. This was when I first experimented with nursing.

My mother had gone to fetch some coal from the cellar and on returning, slipped and fell. The doctor said that she had to stay in bed. My father was in the Air Force and so he was not at home. My brother had just come home from the hospital after an attack of pneumonia. My younger sister was also ill.

When I came home from school each day, I prepared the meals, rubbed my mother's back with alcohol, and gave my brother his medicine. Pleased with so much responsibility, I decided to become a nurse, and I have never changed my mind.

While I was in Girl Guides, I took the course in first aid from the St. John Ambulance Association, and was able to give first aid to a friend who had been severely burned.

I feel that I would like to learn to care for the sick, and help to relieve their suffering. I think too that this knowledge would be very useful to me if I were to marry and have a family.

— *A prospective student nurse.*

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NANCY H. WATSON, R.N., REGISTRAR,
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   (c) Eight week course in Care of the Premature Infant.

---

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 8

MONTREAL, AUGUST 1960

FAITH AND BEGINNING

THE PRESIDENTIAL ADDRESS mentioned on your program seems to refer to something rather formal and learned. However, I wish to inform you immediately that what I prefer to call a rendering of accounts will be neither formal nor learned. I have had the occasion to listen to many presidential addresses in my career. Some I have found to be masterpieces of rhetoric; others merely made me aware that the president should have been a statistician. There were those that took you back into the far-away past — not to measure the progress, but merely to dwell on an epoch the main charm of which seems to have been the contrast with the present state of affairs. One is tempted to imitate a colleague who recently stated very emphatically that she would not make a presidential address but because there are executive secretaries to keep presidents in line with the by-laws, she prudently went on to do her duty and so shall I.

Being elected the president of a national association is indeed an honor but the mandate that is given with the title carries a great many responsibilities. It is only fitting that the president should render an account of her stewardship.

This biennium was placed under the egis of Faith. Looking back over some of the accomplishments of the last two years we find many reasons to take comfort in the fact that faith invested



(G. Carpenter)

ALICE GIRARD

in Canadian nurses has brought many rewards. The Pilot Study on the Evaluation of Schools of Nursing, which is without any doubt the main achievement of this biennium, economically speaking at least, was a pure act of faith since the lack of funds for such an undertaking was just as acute two years ago as it was in 1946 when the general meeting of this Association did not deem it possible to implement the Executive Committee's recommendation for the initiation of "a plan of action on accreditation as soon as possible." You will hear through other reports on this subject of the splendid manner in which nurses responded to the confidence placed in their generosity and understanding because they knew that the time was ripe for such a Study and that there should be no further delay. Many provincial associations, already burdened with financial problems stemming from budgets strained by the purchase or construction of new headquarters, did not hesitate to back this project to the limit of their financial capacity.

No less inspiring was the act of faith on the part of all those who so heartily endorsed this project, knowing only too well that its implementation would require unceasing efforts if they were to reach a goal so long desired but, for most, so difficult to attain.

I add nothing to your knowledge when I say that the success of this project is due to the wonderful qualities of the person we were fortunate in having as its director. I pay tribute to the fine leadership Miss Mussallem gave to those who worked with her all through the various stages of the study, as well as to the understanding, friendliness and warmth which she gave so abundantly to all those with whom she came in contact during her visits to each province.

Another milestone which must be recorded among the highlights of this biennium is the attainment of a goal first envisioned some years ago by the capable editor of our own journal, *The Canadian Nurse*. Today, every nurse who is a member of this Association is also a subscriber to our journal through her provincial association registration fee. This was no small task in itself but to culminate this achievement we have also graduated into the multi-language class — the French-speaking nurses can now read in their own language the same journal *L'Infirmière Canadienne*. Results such as this do not happen without a great deal of planning, of persuasion, of give and take. In my opinion, one of the best signs that we are a mature organization is the fact that this has been possible. It is with great joy that we now feel this sense of togetherness in our goals, especially at a time when some countries are deploring narrow-mindedness and prejudice. We can be justly proud of the unity and strength we are achieving.

In the last two years we have seen the development of governmental plans for hospital insurance, with every province but one cooperating, and this one making valiant efforts to catch up with the others in the very near future. It is inevitable that plans of such magnitude could not be implemented without a great deal of re-evaluation of objectives and methods on the part of all disciplines concerned. Nursing, which had already started its own soul-searching and self-evaluation, saw its thinking crystallize in the form that was urgently needed to seek answers to some of the burning questions posed by the administrators of these projects. Recognizing the urgency of providing suitable answers a CNA Research Committee was formed. It has not yet produced the answers because research is a painstaking process which needs time, know-how and money. The lack of this last element (the committee was approved after the budget was voted!) has certainly slowed down the tempo of progress because it must be possible to meet to work efficiently together, especially in the early stages of a program. However, the committee has started the research index. It has made a thorough review of all projects directed to it. It has assigned priorities and redistributed some studies to standing committees or provincial associations who seemed to have adequate and appropriate resources to conduct the research. Most of the more urgent projects directed to the Research Committee hinged on such fundamental questions as: What is nursing? Is what we call professional nursing today truly professional and if not, what do we want it to be? What system

of nursing education should we favor and based on the findings, what changes are needed in nursing service? If the recommendations of the Pilot Project on Evaluation of Schools of Nursing are accepted by the membership of this association a uniform approach to the answering of these questions would be a natural outcome.

In relation to governmental hospital insurance plans, it has been our privilege during this biennium to present two Briefs. The first was submitted to the Minister of National Health and Welfare as an outcome of a visit made to the Minister for the purpose of paying our respects and of discussing current affairs pertaining to nursing. This Brief, presented in February 1959, dealt with financial assistance for nursing education. Its presentation to the Dominion Council of Health led to an invitation to meet in November of the same year with the Advisory Committee on Hospital Insurance at which time we presented the second Brief. The latter contained suggestions for the organization and financing of hospital schools of nursing. It is encouraging to report that at both of these meetings we received a warm welcome and were given a great deal of time after the presentation of the Brief for informative discussion.

Another event that is worthy of mention is our venture into the field of extension courses. With the financial assistance of the Kellogg Foundation, and jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association, we are developing a program of Nursing Unit Administration through home study and intramural sessions. The outline of the course will be approved by the two responsible organizations; lessons will be tested in pilot studies. The selection of applicants is expected to be completed by next June. It is our hope that the course will begin in September, 1961 in English and in French by September, 1962. We have been fortunate in obtaining for this experiment the services of a well qualified nurse, Miss Kathleen Ruane, who will bring experience and enthusiasm to this project.

We look upon this course as a means of fulfilling a need in an area where needs are great. We have approximately 7000 head nurses in our Canadian hospitals, the vast majority of whom will not be able to attend universities for advanced preparation. Though this course will cover only one segment of the functions of a head nurse, it is expected that institutions and provincial nursing associations will continue, through institutes and in-service programs, to help these nurses to become better equipped for what is considered as one of the most important positions in the hospital.

After this cursory review of the state of affairs in the field of nursing at home, I would like to share with you some of the impressions gained by attending the meeting of the Board of Directors of the Internation Council of Nurses held in Helsinki last summer. One is impressed with the prestige that Canadian nursing seems to command among the nurses of the world. This we owe to a number of leaders in Canadian nursing who, at various times and in various ways, have made outstanding contributions in the international field. Being exposed to the problems that confront an international association is an education in itself and at times a painful one. It is a great responsibility for your president to vote on your behalf on such issues as racial prejudice or the barring of member associations, when it is so difficult to determine objectively the degree of responsibility that is applicable to the association, how much to the political government. On the other hand, it is pleasing to observe how the ICN is growing in influence. Two of its newest features will be the appointment of a consultant on the economic security of nurses and the inauguration of the new Student Nurses' Unit.

In considering the growth and development of the ICN we must not lose sight of the fact that, numerically, the CNA is the third largest member association. If we expect to retain our prestige and to play the role which is befitting our rank in this association, Canadian nurses must take a wider interest in world affairs in general and in world nursing in particular.

As I was writing these lines I remembered a page from the book "Gift From The Sea" by Anne Morrow Lindbergh. She wrote:

We are asked today to feel compas-

sionately for everyone in the world; to digest intellectually all the information spread out in public print: and to implement in action every ethical impulse aroused by our hearts and minds. The inter-relatedness of the world links us constantly with more people than our hearts can hold. Faced with this dilemma, what can we do?

Because we cannot deal with the complexity of the present, we often override it and live in a simplified dream of the future. Because we cannot solve our own problems right here at home we talk about problems out there in the world. Can one make the future a substitute for the present? And what guarantee have we that the future will be any better if we neglect the present? Can one solve world problems when one is unable to solve one's own? Where have we arrived in this process? Have we been successful working at the periphery of the circle and not at the center? If we stop to think about it, are not the real casualties in Modern Life these centers called: the here, the now, the individual and his relationships.

The here, the now and the individual have always been the special concern of the Saint, the artist, the poet and, from time immemorial, the woman. She has never forgotten the uniqueness of the individual, the spontaniety of now, the vividness of here.

When we start at the center of ourselves we discover something worthwhile extending toward the periphery of the circle. We find again some of the joy in the now, some of the peace in the here, some of the love in me for thee.

The author goes on to say "and the waves echo behind me, 'Patience and Faith. This is only a beginning." It is with these two words — Faith and Beginning — that I will end this address, for it is my belief that as long as we have faith we will always have the spirit for more beginning.

ALICE GIRARD
President
Canadian Nurses' Association

The ICN Committee on revision of Constitution and Bylaws plans to draw up a format to be used by national student nurses' associations in drawing up or revising their constitutions. This will serve as a preparatory step for the national student associations who are seeking membership in the International Student Nurses' Unit.

Some national nurses' associations, in recognition of the responsibilities placed upon more fortunate peoples by World Refugee Year, have contributed substantial sums of money to ICN headquarters for use in relief work. The various branches of the Northern Rhodesia Nurses' Association hope to "adopt" refugee families and take a personal interest in them.

Program plans for the 1961 ICN congress are progressing nicely. His Excellency Lord Dunrossil, Governor General of Australia, will open the congress and the Viscountess Dunrossil has accepted an invitation to be its Patron.

— *ICN News Letter* No. 85

* * *

'Twixt optimist and pessimist
The difference is droll:
The optimist sees the doughnut,
The pessimist, the hole.

— McL. WILSON

U.S. Dept. of Agriculture food scientists advise that squeezing a frozen food package to test its hardness is not a guide to the quality of its contents. In a recent release they say, "A frozen food package feels just as solid after storage at 20° F. as it does after storage at zero, but storage at zero or below is needed to maintain the original quality of the frozen food.

Quality of frozen food exposed to temperatures of 20° to 25° F. declines quickly. The damaging effects of such high temperatures cannot be seen or tasted in the early stages, but during just one day of storage at 20° changes occur that will ultimately affect flavor and appearance. Other changes such as loss of vitamin C also start. Moreover, quality lost cannot be restored by lowering the temperature to zero or less, even though this prevents further damage.

* * *

For true success in life there is nothing more important than defeat. A nurse must have chosen for herself a very poor and pitiable ideal if she finds that she can live up to it constantly for, any one who always lives up to the standard she has set for herself, has chosen an ideal that is hardly worthy of the name.

W. N. MONTEITH in *Life and Work*

HYPOTHERMIA

E. S. Russell, M.D.

Generally speaking, it is rather difficult to find a landowner who has much to say in favor of the groundhog or woodchuck. And yet human beings owe him (and other animals with similar habits) a vote of thanks, for his hibernating habits taught us how to save life through use of hypothermia.

Hypothermia is an explicit word used to designate an exciting newcomer to the field of anesthesia. It is another adjunct in the better preparation of the patient for surgical procedures. Cooling permits attack on previously forbidden sites and more leisurely access to sites formerly operated upon in great haste. These include aortic replacements, intracardiac procedures, and interference with cerebral blood flow. A common example of the latter is the berry aneurysm, cause of subarachnoid hemorrhage.

How does hypothermia change things? Every living tissue and organ requires a continuous supply of oxygen to permit its existence. Bering[1] and his associates in Boston, working on monkeys, showed that the brain requires 2.5 to 4.7 cc. of oxygen per unit. This utilization is reduced to 0.8-1.0 cc. when the brain temperature is reduced to the range of 27-31 degrees centigrade. Thus, the oxygen consumption is one-fourth that of brain tissue at normal temperature. It would follow that not only is the oxygen consumption substantially reduced, but the survival time of the tissue in the absence of continuous supply is increased several fold.

At normal temperature the surgeon may interrupt the blood flow to vital tissues such as brain, liver and kidneys for periods of only 2-4 minutes. The same tissues, when cooled, will resist damage from such supply interruption for 6-10 minutes or more.

How are patients cooled? As in any new technique, there are several methods of achieving the same result and the best way, or ways, has yet to be established. Surface cooling is simple and is in most common use. The unprotected body surface is exposed to ice cubes or water or a mattress through which refrigerants are circulated. This proceeds until the body temperature is suitably reduced. Other methods which are a bit more complicated, but which have certain advantages, include extracorporeal cooling and body cavity cooling. Extracorporeal cooling is the withdrawing of blood from the body, passing it through a suitable refrigerant coil and then re-injecting it into the circulation. Kimoto[2] et al have reported selective brain cooling by irrigation of that organ with cooled blood. With this technique the brain temperature is considerably lower than the general body temperature. This appears to be a method of some promise.

During the cooling process, there are a couple of factors that require some attention. Nearly one hundred years ago, Claude Bernard[3] realized that shivering keeps an animal warm by enormously increasing the metabolism. Since shivering is a normal response to a cold skin, then we can expect the same to occur during the cooling phase. The other factor in addition to shivering, is peripheral vasoconstriction. It directly delays cooling by preventing the blood from circulating through the cold skin and subcutaneous tissues. It is an excellent protective reflex for all excepting those whom we wish to cool.

The anesthetist prevents or controls shivering and vasoconstriction by preoperative medication and anesthetic drugs. When talking about the advantages of reduced metabolism, we must note that drug metabolism is also affected. For this reason, drugs such as thiopentone are used only in small

Dr. Russell is clinical assistant in anesthesiology at Queen's University, Kingston, Ont.

doses or avoided and replaced by those excreted by the lungs.

Since it is almost impossible to start an intravenous infusion in a cooling patient, it is established at the time of anesthetic induction. Other instruments used are the electrocardiograph with scope, the electrical thermometer, and frequently an electroencephalograph.

Once the patient is asleep and in the cooling bath, it is necessary to know the body temperature. This requires careful evaluation since it is not the skin temperature that matters, but rather that of the heart and brain. Electrical thermometers are used to record rectal, skin and esophageal temperatures. From these it is possible to get a picture of the rate of cooling, the body core temperature and the drift that may be expected.

A word about "drift" is indicated. It is found that when a patient is cooled from 37° C. to 32° C. and then removed from the bath, the temperature will continue to fall 2-4° C. Why is this? It happens because the blood continues to be cooled by the cold surface of the body. Invariably, the skin or muscle temperature is several degrees below the esophageal temperature and it takes some time after cooling is discontinued for the two to become equal. This phenomenon is well appreciated and actually utilized in that the patient is removed to the table and the operation started as the patient's temperature continues to fall. The temperature is controlled by the use of heat or cold as indicated. Circulated hot air, produced by various types of heat cradle is satisfactory in the rewarming phase.

Hypothermia presents certain hazards to the patient. It is of interest to mention the more common ones. Ventricular fibrillation has received much attention since it is a fatal complication unless successfully treated in a very few minutes. Actually, the value of hypothermia is evident when effectual resuscitation after 10-15 minutes of arrest has no associated cerebral damage. Treatment consists of local heart warming by pouring warm saline directly into the chest, electrical defibrillation and occasionally the use of drugs.

The second complication is skin damage. Frost-bite is a real danger, especially if vasoconstriction is allowed to occur during the cooling phase. Burns may occur due to over-zealous warming methods such as "too hot" hot water bottles.

Indications for hypothermia are both surgical and therapeutic. The principle is always the same — reduction of oxygen requirements permitting a temporary decrease or cessation of blood flow to the brain. Surgical procedures benefitted by this increase in operating time include those performed on heart, great vessels, brain and cerebral vessels.

One must remember that there are many procedures, especially those involving the heart and great vessels, which require more time than can be permitted by hypothermia. It is here that the elaborate heart-lung machines, which permit prolonged circulatory bypass, are of such value.

Gray[4], in 1955, pointed out the value of hypothermia when prolonged hypotension was required. Disease conditions where it is of value include thyrotoxic crisis and hyperthermia due to drugs or disease. Hypothermia may be used after a cardiac arrest during operation as it probably reduces the residual brain damage.

In conclusion, hypothermia is a safe and practical procedure that is of great value in surgery which requires short periods of circulatory interruption or prolonged periods of hypotension. It is an exacting and tedious discipline which, when adhered to carefully, makes possible the restoration to health of many patients previously incurable. The nursing contribution is of special interest and value because you will all see, and many of you will contribute, to the changes and advances that will be made in this new field of medicine.

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The Era of Open-Heart Surgery

DONALD B. EFFLER, M.D.

The nurse who specializes in the care of patients following heart surgery must use every bit of her knowledge, skill and ingenuity every moment she is on duty.

Hypothermia

ALTHOUGH CERTAIN phases of heart surgery can be traced back to the turn of the century, it is only a few years ago that surgeons began to operate within the human heart under direct vision. The earliest of the so-called "open-heart operations" was performed as the patient's circulation by-passed the heart while the patient was under hypothermia. Utilizing various cooling techniques these operations were performed after the body temperature had been cooled to about 85° F., to permit by-pass of the heart for appreciably longer periods than could be tolerated at normal temperature. In bringing about by-pass of the heart, the venae cavae are occluded to prevent or to divert the systemic venous return to the right side of the heart. In this manner the heart rapidly empties itself of all blood except for the amount that returns through the coronary and bronchial circulation. This, of course, drastically reduces the normal cardiac output and within two or three minutes serious lack of oxygen will become apparent in the central nervous system and other important organs of the body. By cooling the patient the safe period of tissue anoxia may be extended up to eight or nine minutes.

Utilizing hypothermic techniques, surgeons were able under direct vision to close defects in the atrial septum, and to open deformed valves in the pulmonary artery. The disadvantage of this method is obvious. The extremely rigid time limit within which the surgeon must work, forces such an operation to become a hasty affair that is performed under considerable pressure. It takes little imagination to see that the clock on the operating room wall becomes the surgeon's mortal enemy, as it relentlessly ticks off the vital moments within which the operation has to be completed. Yet, limited though the technique of hypothermia is, it played a vital part in the development of our present methods of modern open-heart surgery.

Dr. Effler is in charge of the Department of Thoracic Surgery, the Cleveland Clinic Foundation and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

Cross-Circulation Technique

Open-heart surgery, as we view it today, began in 1954 with the cross-circulation techniques developed by Dr. C. Walton Lillehei and his associates at the University of Minnesota. The cross-circulation operation required the patient to have a compatible donor of identical blood type. By an intricate system of arterial and venous cannulations, the circulation of the patient and of the conpatible donor were united, and the healthy heart of the donor supplied the arterial blood flow to the patient while his by-passed heart was opened for repair. This technique enjoyed a limited use. It proved conclusively that operations within the beating heart could be performed almost at the surgeon's leisure, if the remainder of the patient's body received an adequate circulation from a proper source. The disadvantages of the cross-circulation procedures are obvious: the compatible donor assumes a tremendous personal risk and the procedure is practical only in patients who are small.

Pump-Oxygenators

From the lessons learned with cross-circulation techniques came the development of the pump-oxygenator. This obviated the need for the compatible donor. Pump-oxygenators of every description have been developed in laboratories throughout the world. These complex instruments are referred to as "heart-lung machines" or, less properly, "artificial" hearts. In es-

sence, a pump-oxygenator is a device that will maintain the patient's own circulation during a period of total by-pass of the heart and, at the same time, will properly oxygenate the unsaturated blood that normally would be returned to the patient's heart.

Although there are many different types of pump-oxygenators, each employs one of three basic principles:

a. *Bubblers,* which diffuse oxygen in the form of tiny bubbles directly through the blood within the machine reservoir;

b. *filmers,* which expose the blood to oxygen by the use of screens or metal plates as the blood passes over the metal surface in a thin film created by surface tension;

c. *permeable membranes,* through which oxygen and carbon dioxide diffuse to reach or leave the blood in a manner similar to the normal physiologic process of the human lung.

Each of the three methods has its distinct advantages and disadvantages. Nevertheless, there are excellent oxygenators in use today based on each of the three basic principles listed above. Although open-heart surgery utilizing the pump-oxygenator is at present only four years old, it is remarkable how widespread the clinical use of the ingenious device has become. Curative operations are offered to heart patients in most major communities today. Whereas the ultimate in the pump-oxygenator has not been reached, it is amazing to see the refinements that have already developed as this type of apparatus has become more efficient and safer in each year of its short growth period.

Mere possession of an expensive pump-oxygenator alone by no means completes the picture. In paraphrased words, a slogan such as "Have oxygenator, will operate" is, in itself, meaningless. The surgeon alone cannot utilize the device. It requires the cooperative effort of other specialists. Nowhere in surgery and medicine has the need for well-integrated team play become so apparent. In modern heart surgery utilizing present pump-oxygenator techniques the head surgeon no longer stands out as the key figure in the patient's treatment. Rather, the responsible surgeon is the captain of a diversified team, all highly skilled and dedicated to the program that will best serve the patient's need.

The Team

The modern heart team consists of:

1. A surgical core, usually two thoracic surgeons and two surgical residents,
2. two anesthetists,
3. at least two operating room nurses trained in this type of work,
4. a pump-oxygenator unit comprising two or three technically trained persons who understand the entire workings of the pump-oxygenator, and are well grounded in the physiologic aspects of total body perfusion.
5. In addition to the operating room personnel there are blood bank technicians specially trained to process the vital blood reservoir necessary for such an operation.
6. Last of all is the Constant Care Unit where the patient will spend the most critical time of his life — the postoperative period. It is safe to say that the demands made upon the personnel who are responsible for such a unit have developed the epitome of nursing skill. No group of patients in the history of medicine receive any greater degree of skillful nursing care than is provided the open-heart patients.

Nursing Problems

Let us follow a patient from the operating room to the Constant Care Unit after repair of an intracardiac lesion, to gain some idea of the nursing problems involved. The patient has an indwelling cannula in his femoral vein. Several chest tubes afford water-seal suction drainage. Electrodes applied to each extremity permit continuous recording of the electrocardiogram. A nasal tube provides constant gastric decompression, and a blood pressure cuff is worn continuously for several days after operation. In addition to the multitudinous details of preparation necessary within the unit, the nurses apply orderly system to what appears to be a chaotic phase of the patient's postoperative period.

While this is being done, blood specimens are taken for essential body chemistry determinations. A roentgenogram of the chest is made by portable equipment. Infusions of blood, fluids,

and various drugs are prepared and administered. A seemingly never-ending series of observations are recorded for an up-to-the-minute running record of the patient's progress. The nurses become familiar with the values of basic body chemistry determinations. They learn to know the meaning of various pH determinations of the blood, CO_2 combining powers, and assorted hemoglobin values. They become amateur observers of the monitoring electrocardiogram and frequently can detect premonitory early changes in the patient's electrocardiographic pattern. They check the patient's body temperature, since he is prone to have a rapid fall or rise in temperature, either of which can be detrimental at this stage of recovery. If a fresh tracheotomy tube has been inserted, the added responsibility of continual tracheal care must be shouldered by the nurses.

Perhaps the most significant observation of all is the absence of chairs in the Constant Care Unit — here, this basic unit of furniture is classed under unnecessary impedimenta. This is one place where the on-duty nurse rarely has an opportunity for sitting. Even the recording of vital data is performed at a table that stands by the bedside.

To some, this description will sound like an exaggeration designed to build up the prestige of the highly specialized nurse. Actually it only tells part of the story. It is my firm conviction that this new form of nursing specialty, and the wonderful people who have made it possible, need no form of build-up — only recognition of the service that they are performing in the fascinating field of open-heart surgery.

Neurosurgery and Hypothermia

Barbara Rowland

Modern methods of anesthesiology make it possible for the surgeon to carry out operative procedures in vital areas of the body with greater safety for the patient.

Miss Baxter was 50 years of age and worked as a stenographer for a law firm. It was at the instigation of a friend that she finally sought medical help. Her employer and some of her friends noticed that she had developed a speech defect characterized by slurring and hesitancy. She also became untidy in appearance and disorganized in her surroundings. She did not display the interest in her work that she had previously and errors in typing went uncorrected. Miss Baxter was aware of her typing mistakes and of her difficulty in dressing but she felt that this was due to a numbness of her left hand. She also felt more tired than usual but she blamed this on personal family problems. She had been admitted to hospital previously for a thyroidectomy and later for swelling of her left foot due to a "blockage of a vein." About a month prior to this admission she had an episode of severe headache in the right temporofrontal region accompanied by vomiting. After a few hours the pain subsided but the vomiting persisted. The headaches recurred periodically but were never as severe nor accompanied by vomiting.

Diagnostic Procedures

A diagnosis of right parietal lobe tumor was made, based on the results of physical examination, history, and various tests. During the neurological examination, Miss Baxter was found to be slightly confused and denied having symptoms that concerned her condition. The muscles of the upper and lower extremities were generally weak. She had left facial weakness and her tongue and lips seemed a bit thick. On smiling, the right corner of her mouth

Miss Rowland prepared this study while she was an intermediate student at Kingston General Hospital.

retracted more than the left. Her tongue was found to deviate slightly to the left. The left pupil seemed slightly smaller than the right. Her left arm was clumsy and movement of the left index finger to her nose was poorly coordinated. A sample of her typing demonstrated clumsiness, lack of coordination and ignorance of her left hand.

Sensation was tested with her eyes closed. Simultaneously touching both left and right hands resulted in the patient replying that the right only was touched. She was unable to distinguish between 8, 4 or 0 traced upon the palm of her left hand. The recognition of form was tested by having her feel objects with basic outlines such as cubes and triangles. *Asteriognosis* (inability to recognize objects or forms by touch) was demonstrated with the left hand. An interesting aspect of this examination was the patient's very firm denial that she was unable to distinguish form. It was later noted that if the nurse bringing her medications approached from the left she would have to cross to the front or right side before Miss Baxter would recognize and take her medications.

The patellar reflex was limited in the left leg but normal in the right. Hair on scalp and eyebrows was rather scanty. Sometimes this is a sign of hypothyroidism but, in this instance, a thyroid function test showed normal thyroid activity. A *pneumoencephalogram* (replacement of the cerebrospinal fluid by oxygen injected into the spinal subarachnoid space for x-ray purposes) showed the gas filling only the cisterna magna, some of the subarachnoid spaces and the fourth ventricle. No oxygen passed into the third or lateral ventricles which indicated an obstruction. An *angiogram* (injection of a radiopaque dye into the carotid artery followed by x-ray visualization of the cerebral arteries and veins) showed evidence of a fairly large tumor in the right parietal lobe causing intracranial pressure. Skull x-rays showed evidence of a tumor in the right parietal lobe. An *electroencephalogram* (a recording of the activity of the brain measured in electric current) showed a marked slow wave abnormality in the right temporoparietal area. These findings were sufficient to confirm the diagnosis of right parietal lobe tumor. Plans were made for its surgical removal.

Patient Preparation

When told of the impending operation, Miss Baxter remained calm and cooperative. She gave no sign of apprehension, appearing, in fact, quite unconcerned. Preparation for surgery included deep breathing and coughing exercises taught by the physiotherapist. Potassium chloride was given three times a day. Potassium is essential to normal electrolyte balance, heart action, and muscular control of the body. Blood was taken for grouping and cross-matching because the operation is a long one. Prior to the angiogram, Miss Baxter had received a general anesthetic and during the procedure she had an episode of laryngeal spasm and became quite cyanotic. Preanesthetic medication this time included phenergen, a potent antihistamine. Skin preparation was done in the operating room. It involved shaving the right side of the patient's head and cutting the remainder of her hair short. The hair which was cut off was saved and returned to her room.

Operative Procedure

The operation summary read:

> Right parietal craniotomy under hypothermia for removal of meningioma, right parietal lobe, complicated by cardiac arrest during operation, requiring thoracotomy and cardiac massage.

Hypothermia is used when it is desirable to have a lessened rate of metabolism thus lowering the need for oxygen to the vital centres. Study of the anatomy of this particular area reveals that it is very vascular. Surgery here is likely to cause an interruption in the circulatory system. For this reason hypothermia was used.

The dangers to consider are that the heart may fibrillate or the patient may go into cardiac arrest. However, because of the lowered metabolic rate in hypothermia there is less danger of brain damage due to lack of oxygen and the surgeon has more time for heart stimulation. Miss Baxter's heart went into fibrillation. Her chest was opened and her heart stimulated to regular activity. The operation resumed without giving the surgeon too great a sense of working against time.

Postoperative Care

When the operation was finished, the head nurse on the ward obtained permission to see the patient. She found that Miss Baxter was still in the operating room. The room was so cold that the nurses wore cardigans under laboratory coats while the patient lay on the operating table with nothing over her excepting a cotton sheet and with ice bags to her groins and axillae. Her respirations were between 7 and 9 per minute. She responded well verbally and asked for a blanket. Her color was good. She moved about well. It is interesting to note that although she talked quite freely and appeared to recognize the nurses, she had no recollection of this phase of her recovery when she was questioned later.

During this period she had esophageal and rectal thermometers in position. These were connected to an electrical device that registered the patient's body temperature. A physiotherapist helped the patient with deep breathing exercises. Her temperature was kept at 34°C. and later 37°C. If it went below these levels ice bags were removed; if it went above icebags were added. Throughout the operation and during her recovery an electric warming blanket was kept in readiness under the patient in case she "drifted" too far below the desired temperature.

Miss Baxter was transferred to her bed but kept in the operating room overnight since the room had to be very cold. The surgeon wished to maintain the slight degree of hypothermia for at least 48 hours. In actual fact this "cooling" treatment continued for several days. In the morning preparations were made on the ward for transferring the patient to her own room.

1. *Cooling the room* This was accomplished quite simply by opening the window and closing the room door since it was cold outside.

2. *Throat suction equipment* A portable electric suction was kept on hand. This equipment was certainly life-saving in this instance.

3. *Emergency tracheotomy set and tray* This is a fairly routine request in our hospital postoperatively, but it is seldom actually used. The easy availability of this set was to prove invaluable to us this time.

4. *Emergency drugs* Levodromoran (1-2 mg.) was to be on hand at all times for the control of shivering and sodium luminal (gr. 2-4) for the control of twitching. The interne or the doctor decided the dosage to be given but it simplified matters to have the medication so easily available. Levodromoran is a potent, morphine-like analgesic and sodium luminal has a selective depressant action on the motor cortex of the brain.

5. *Sphygmomanometer, stethoscope and flashlight* These were used in observing vital signs. This is of major importance in brain surgery where a deviation may be the first indication that a serious change is taking place in the patient's condition.

6. *Special mouth care tray* Special mouth care is important with all seriously ill patients but especially so with patients who have had brain surgery. The patient was unable to clean her teeth, swallowing was difficult, and she took very little or no fluids by mouth.

7. *Intravenous equipment and solutions* Flasks of glucose and water, saline and water, with electrolytes added were available in the room. This avoided the frequent opening of the door and the entry of warm air.

8. *Oxygen tank with B.L.B. mask and nasal catheter* This was not used until it became necessary to give Alevaire inhalations.

Nurses from the ward were assigned to 8-hour special duty with Miss Baxter so that any change in her condition would be noted immediately.

When she returned to the ward, the rectal thermometer, enclosed in a metal container, was still in place. From this the amount of cooling or warming needed to maintain the desired degree of body temperature was determined. The esophageal thermometer had been removed. An underwater drainage system cleared the thoracic cavity of secretions collecting as a result of the incision into the chest to massage the heart. A retention catheter drained the urinary bladder. The patient's only covering was a sheet. Her whole body had a "pink and white complexion." She responded well, appeared alert and was not shivering. Avoidance of shivering was important as this is a warming mechanism of the body.

Immediate nursing care included

turning the patient every hour. The nurses encouraged Miss Baxter to turn herself which she did quite easily. Her blood pressure, pulse, respirations and temperature were noted every quarter hour. She was encouraged to take fluids by mouth. An intravenous was running but the doctor did not want to give too much fluid directly into her circulatory system. Ice bags were applied to the groins and axillae as needed to keep the body temperature close to 37°C. They were carefully wrapped in order to avoid a "burn" and, of course, frostbite.

Deep breathing exercises were done every hour though coughing was avoided. A physiotherapist came to the room periodically to help Miss Baxter with this exercise but it was largely the responsibility of the nurses. No bathing was allowed. The doctor wished to avoid friction to the skin and since the patient was so cool, there was actually little need for bathing. It was necessary to observe movement of her extremities. Miss Baxter responded well to stimulation but her left arm was stiff. As with all major surgery, a careful check of intake and output was kept.

To report immediately *any* change in the patient's condition required constant attention to and good interpretation of signs and symptoms. Charting had to be accurate and verbal reporting at the change of shift had to be thorough. At one or two o'clock in the morning even normal conditions for a postoperative seriously ill patient may tend to appear abnormal. To call someone not in constant attendance upon the patient, to confirm a *slight* change in condition is not too helpful since it is very difficult to judge on the spur of the moment. Therefore the nurse caring for the patient must assume the full responsibility for this.

Chloromycetin was given intramuscularly every six hours in 500 mg. doses and 2,000,000 units of penicillin every three hours. The initial dose of Dilantin was 150 mg. and was to be followed by 100 mg. four times a day. Dilantin is an anticonvulsant drug related chemically to the barbiturates.

During the first to third postoperative days Miss Baxter's eyelids became swollen but her pupils dilated equally and responded normally to light. Blood pressure readings and pulse rates remained fairly constant. Body temperature was maintained at 37°C. She was unable to grip with her left hand and she complained that her left shoulder was stiff but she was able to move her arm. There were occasional jerky movements of the left hand. The left side of her body twitched periodically with the twitching spreading to the face and the left eye. Sodium luminal gr. 4 was given intramuscularly to relieve the twitching but it remained pronounced in the left hand. The patient was alert and responded well. Her speech was slurred but she appeared well oriented to her surroundings although she did not realize that the operation had been done. There was little drainage from the chest catheter.

Postoperative Complications

During the afternoon of her first day on the ward Miss Baxter's respirations became labored. A large amount of mucus collected causing a rattle on expiration. The doctor decided to perform a tracheotomy because of the excess mucus. The patient seemed unaware of the operation though she responded to requests for cooperation. The cannula of the tracheotomy tube was suctioned frequently and a large amount of thick, pale mucus removed. The routine of turning and deep breathing was continued. A turning sheet was placed on the bed to help Miss Baxter when she needed assistance. Sustagen, a therapeutic food providing complete nourishment was given by means of a gastric tube.

By the fourth postoperative day, the twitching became convulsive and was more frequent and prolonged. It started in the left corner of the mouth and radiated to the left eye, down the left side of the face to the left arm and hand. Sodium luminal was given intramuscularly p.r.n. in addition to Dilantin. Respirations were slow and deep with a moderate amount of grayish mucus being suctioned through the tracheotomy tube. Her pupils reacted less to light. The temperature in the room had been controlled by the simple expedient of opening the window and closing the door. Unfortunately the weather became very mild. Fans blowing over ice made it possible to maintain the cold environment. A cut-down was established for intravenous fluids

since Miss Baxter was now taking nothing by mouth and the gastric feeding was unsatisfactory. Daily serum electrolytes and chest x-rays were ordered for three days. The chest drainage was discontinued.

On her fifth postoperative day Miss Baxter responded to painful stimuli and the spoken word but her respirations increased to 25 per minute. Expirations became very forceful and her face was very flushed. The surgeon was called. He suctioned the patient deeply through the tracheotomy tube. Many cast-like collections of mucus were removed. Alevaire inhalations with a mask over the tracheotomy opening were ordered to help loosen the mucus in the respiratory tract. Deep breathing was encouraged. The indwelling rectal thermometer had been removed after 48 hours as it was felt it might damage the rectal mucosa. Temperature by rectum, pulse and respirations, along with the blood pressure, were taken only once every hour. The methods used for "cooling" the patient were gradually discontinued and the room was allowed to warm. It was interesting to note that although Miss Baxter's skin felt really cold to touch, she never complained of feeling cold herself. Because of this "cooling" Miss Baxter did not "run a temperature" and hyperthermia, a complication of brain surgery, was avoided.

By the ninth day a cork was inserted into the tracheotomy tube as tolerated. The head of the bed was elevated 30 degrees for short periods. Respirations were easier and regular. At this time the patient was receiving Sodium Dilantin 100 mg. t.i.d. orally. Her cut-down was discontinued and she progressed from fluid to soft diet. Miss Baxter was talkative and cheerful to the extent of being slightly euphoric. All medications continued with the addition of a sedative, phenobarbital gr. 1½, in the evening. The tracheotomy tube, retention catheter and rectal temperature were discontinued. Deep breathing, coughing and observation of movements continued every hour. Procaine penicillin was given intramuscularly every 12 hours in a 1,000,000 unit dosage and the chloromycetin dosage was changed to 250 mg. q.i.d. Aerosol inhalations continued to be given three times a day with the mask now being placed over the face.

Miss Baxter was permitted to have two visitors for 10 minutes each day. She was allowed to have a daily sponge bath, and eventually a tub bath. With the help of the physiotherapist she progressed from "dangling" her legs to walking. Her walking was very clumsy at first and it required considerable patience to take just a few steps. She seemed to be actually helped by her slight state of euphoria which made her consider all tasks as a bit of a "lark."

Rehabilitation

This was a continuous process starting with deep breathing exercises prior to surgery. As soon as she roused from the anesthetic, Miss Baxter began these exercises. Throughout her entire convalescence she was encouraged to help herself as much as possible. Gradually the head of the bed was raised 30 degrees, and activity progressed to sitting upright with feet dangling. Leg and hand exercises were supervised by the physiotherapist. Hands and fingers regained their strength day by day. Soon she was up in a chair, then walking with assistance. She still had a left-sided weakness with a tendency to lean to that side while walking. Always in the best of spirits, she seemed pleased with her accomplishments and became more relaxed and agile as time went by, often mingling with other patients.

Four weeks from her admission date, Miss Baxter left the hospital. She was to visit the physiotherapist twice weekly. The doctor wished to see her in two weeks. Her discharge medications included phenobarbital and Dilantin which her doctor told her that she should continue to take for some time. In approximately four months she returned to her work on a part-time basis and progressed to a full eight-hour day. She still had some loss of function of the fingers of the left hand but this was overcome as she used her fingers for typing.

The wheel that squeaks the loudest is the one that gets the grease.—Josh Billings

FIRE AND EXPLOSION in the Operating Room

SISTER MARIE PLACIDE, S.G.O.

The operating room should be one of the safest areas in the hospital but it contains many of the elements that can spell danger and disaster. How are these factors counteracted?

IF THE ACCOUNTS OF accidents on the highway, at work and under other circumstances are shocking to us, then how much greater should be our concern over the impressive number of injuries and the loss of life due to explosions in operating rooms? Patients and personnel have every right to expect the utmost in safety in this hospital area.

The frequency of explosion is at least one in 80,000 anesthetics. In Montreal, the number of accidents per year of this type varies from two to ten. In the United States, within an 11-year period, 1938-49, 69 such accidents were reported — 28 involved fire and 41 were explosive. Ten fires were caused by suction apparatus and seven by the electric cautery. Thirty-two explosions were attributed to static electricity and 69 per cent of these occurred in operating rooms that were not provided with conductive flooring.

It seems unbelievable that the weekly toll of accidents with the attendant investigations, recommendations and warnings have done nothing to decrease the growing number of explosions. Three factors are necessary for explosion: combustible material, a means of igniting it, and oxygen. Unfortunately, the factors are always present in operating rooms. They must be controlled in order to prevent possible accidents. Gas and anesthetic fumes such as cyclopropane, ethylene chloride, ether and even nitrous oxide comprise the combustible material.

To eliminate the danger of explosion we only need to replace these agents by others of a non-explosive nature. This, of course, is not possible at present. As an alternative, we must find the means of using our present agents with a minimum of danger. Since anesthetic and gas fumes are heavier than air, they spread over the floor and accumulate from below upwards. For this reason, to prevent explosions we must avoid sparks at floor level and up to a height of five feet. In arranging for air circulation at floor level, we have to take into account the possibility of accidental leakage from various gas cylinders, defective tubing, and residue in anesthetic machines. All such factors constitute a permanent source of danger.

Accumulation of gas and anesthetic fumes, in conjunction with static electricity, is responsible for the greatest number of accidents and is a constant threat. Static electricity is also involved in almost 100 per cent of fires occurring in the operating room.

We know that there are two types of electricity — the controlled current in daily use and static electricity produced by friction of various substances such as wool, silk, nylon, sharkskin and plastic materials. Static electricity is more marked in a dry atmosphere — that is when the humidity is less than 50 per cent. Woollen bedclothes must not be brought into operating rooms, nor should synthetic materials containing nylon. Cotton only should be permitted.

A product called Negastat that possesses anti-static properties may be used in the last rinse water in laundering. It retains its effectiveness for a comparatively long time.

We must not overlook the question of humidity. It has been established that a high degree of humidity prevents the accumulation of static electricity and thus removes a cause of explosion and fire. However, serious explosions

Sister Marie Placide, is a head nurse in the obstetrical department, Ottawa General Hospital. This paper was presented at Marguerite d'Youville Institute, Montreal.

have been reported in 65 per cent humidity which confirms the existence of other factors as causes of accidents.

Domestic currents of electricity can be controlled while static electricity is a great deal more erratic. It exists everywhere, accumulates in varying quantities on objects, depending upon their degree of isolation or lack of grounding. For example, two objects may carry different charges of static electricity — one having 1000 volts, the other 200 volts. Even without physical contact and at varied distances, the electricity charges tend to come into equilibrium suddenly, producing a spark which is sufficient to induce an explosion if combustible elements and oxygen are present.

Three effective means of preventing sparks are:

1. Avoidance of the use of materials likely to induce development of static electricity.
2. Avoidance of friction.
3. Establishment of contact between objects using a common conductor that prevents formation of different electric charges and eliminates danger of sparks.

This contact can be achieved through the use of small chains or wires that come in contact with the floor.

Conductive flooring is able to eliminate static electricity as quickly as it builds up. This quality is dependent upon the resistance of the flooring, its construction and its composition. Some authorities maintain that good flooring of this type eliminates the necessity for grounding. The floor surface must be non-absorbent, without cracks, fire- and water-proof.

To make cleaning easier as well as to reduce danger of explosion, the flooring must be laid without interstices, no matter how small they may be. It should be of wear-resistant composition. Terrazzo sealed with metal strips is quite in order. Progress in the development of flooring materials is constant and the experts who direct the construction of operating rooms must be alert to the use of materials most likely to eliminate all danger of accident.

How should an operating room floor be maintained? A gentle detergent should be used. Oil and grease must be avoided. It is advisable to add calcium chloride to the mopping solution, eight ounces per gallon. This solution increases floor conductivity, Mopping should either be done in the evening or in the morning before the day's work starts. Waxing must be omitted unless a special wax with conductive properties is used.

To ensure that persons moving about the operating room are free from electrical charges, clothing likely to generate static electricity must not be worn and there must be adequate provision for grounding. If not, contacts between two individuals carrying electrical charges or between an individual and an object may produce a strong enough spark to cause explosion or fire.

Preventive Measures

One of the most effective and economical safety measures for operating room personnel is the wearing of conductive shoes. They can be bought from suppliers of surgical equipment and are provided with different conductive factors. They lose their conductivity as soon as a layer of wax covers the sole so that the latter must be cleansed daily with a good detergent.

Shoes can be made conductive by attaching a band of conductive rubber underneath the heel and fastening the ends to the inner surface of the shoe. The foot rests on the ends of the band. This method is simple, easy and sure. Shoes with nails are dangerous since the nails may produce sparking sufficient to cause an explosion if they come into sharp contact with the terrazzo flooring or a piece of metal.

Personnel who visit the operating room only occasionally such as consulting doctors, x-ray technicians and others, must be checked in some way to determine if they are conductors or carrying an electrical charge. A *conductometer* is very useful for periodic floor checks and may be used for other objects as well.

Another source of ignition is the current used for lights and other equipment. Since inflammable fumes tend to collect from floor level upwards, sparks must be avoided up to the five-foot level. Switches and outlet plugs must be placed at or above this height. All electrical equipment such x-ray machines, cauteries etc. should be in good working order and their setting ap-

proved by the anesthetist. The latter must modify his techniques, if advisable, and evaluate the risks of explosion according to the equipment in use.

Other sources of danger are matches, automatic lighters, alcohol lamps, cigarettes and other objects whose use in the vicinity of the operating room should be forbidden.

Oxygen

The final part of our discussion must be centered around the use of oxygen. In the absence of oxygen, fire and explosion are not possible. The normal oxygen content of the air is 20 per cent — an adequate amount to support combustion and explosion. As soon as the oxygen content increases, so does the risk of accident.

Greasy or oily materials and inflammable liquids must not come in contact with oxygen cylinders, valves or regulating equipment. A special lubricant should be used when one is required.

Summary

The following measures are important in prevention of fire and explosion in the operating room.

1. Anesthetic machines should not be covered with drapes. Shifting the drape can cause static electricity.
2. Ether and alcohol should not be used in skin preparation. Not only can fire result from this but the patient's skin may be irritated.
3. Wool, silk, nylon, sharkskin, nonconductive rubber and plastic should not be used in the area where anesthetic preparations are in use.
4. When inflammable substances must be used, they should be kept well away from the anesthetist and his equipment.
5. Anesthetic machines should be moved cautiously.
6. Drapes, rubber attachments and tubing should be attached and removed with great care. Improper handling may cause static electricity.
7. All personnel should wear conductive heels on their shoes.
8. Conductive flooring should be laid in operating room suites whenever possible.
9. When flooring is non-conductive, objects should be grounded.
10. The use of oils, greases or inflammable liquids around oxygen equipment must be prohibited.
11. When adjusting the oxygen regulator, open or close it slowly in order to prevent dust particles getting into it. Stand to one side when opening the valve and see to it that other personnel do the same.
12. Do not use oxygen regulators for any other purpose.
13. Open cylinder valves fully when they are in use and close tightly afterwards.

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Do you remember that Christ holds up the wild flower as our example in dress? Why? He says God clothes the field flowers. How does He clothe them? First, their clothes are are exactly suitable for the kind of places they are in and the kind of work they have to do. So should ours be. Second, field flowers are never double; double flowers change their useful stamens for showy petals and so serve no ends. These double flowers are like the useless appendages now worn on the dress and very much in the way. Wild flowers have purpose in all their beauty. So ought dress to have nothing purposeless about it. Third, the colors of the wild flower are perfect in harmony and there are not too many of them. Fourth, there is not a speck on the freshness with which flowers come out of the dirty earth. Even when our clothes are getting rather old we may imitate the flower: for we may make them as fresh as a daisy.

FLORENCE NIGHTINGALE, 1878

* * *

A healthy disagreement is often one of the best tonics.

Evaluation of Experience in the Operating Room

Amy E. Griffin, M.S.

Is operating room experience necessary in the basic curriculum for student nurses or could it be eliminated without loss to the learner?

Introduction

Clinical experience in the operating room for students in a basic nursing program is as strongly upheld by some as it is denounced by others. The former claim that the values accruing to the student through this experience are invaluable and irreplaceable. The latter believe that the experience should be limited or eliminated on the undergraduate level as the number of professional nurses utilized in the operating room is being steadily decreased by the increasing utilization of the operating room technician, a classification of auxiliary personnel trained primarily on-the-job. That there is a legitimate role for the practical nurse or technician in the operating room has been demonstrated by experience. The rationale underlying the use of such auxiliary personnel, the scope of their activities, and the consequent changing role of the graduate nurse in the operating room has been discussed on the various occasions.

A review of the literature regarding the inclusion of a period of clinical experience in the operating room as part of the basic nursing curriculum, would seem to indicate that:

1. There are strongly held opinions regarding the value of such experience but relatively little research or study has been done in this area to substantiate or repudiate these views.
2. While some nurse educators have deemed it wise to eliminate operating room experience from the basic nursing curriculum, none has outlined as yet either the areas in the curriculum where the values known to accrue from it may be developed or the reasons why the experience in itself is undesirable.
3. The limited number of reported questionnaires submitted to students and graduates in the few studies that have been done indicate that the experience is considered to be valuable and enjoyable but that certain modifications of the programs would increase their value.
4. Considerable thought has been given to the ways in which operating room experience can be made more meaningful. Certain specific recommendations have been made in regard to the planning and executing of this experience.

Purpose of the Study

This pilot project in action research was an attempt to determine the behavioral changes resulting from a four-week period of clinical experience in the operating room in a specific collegiate program. Answers to the following questions were sought:

1. What is the nature of and how adequate are the learning experiences provided in the operating room?
2. Are the behavioral changes that this experience promotes in harmony with the overall objectives of the basic program and the specific objectives of operating room experience?
3. Do the methods of evaluation give adequate evidence of desirable behavioral changes?

Description of the Sample

This study was limited to a total of 16 students who were divided into four groups of four students each. This represented the total enrolment of a particular class. Each group had four weeks of experience in the operating room. A total of 80-100 hours was spent in this area by each student.

Methodology

1. A review of the literature pub-

This is a condensation of a study done by Miss Griffin as a partial requirement for her Master's degree in nursing from Wayne University in Detroit. During the past months she has been engaged in studies for her doctorate.

lished in nursing and related periodicals 1945-58.

2. A review of the over-all objectives of the curriculum and the specific objectives of operating room experience.

3. A review of the learning experiences provided in the operating room.

4. An analysis of the following evaluation measures to determine the nature of the behavioral changes they revealed and the extent to which they gave adequate evidence of desirability:

a. Student evaluation of experience by questionnaire and diary

b. student self-evaluation

c. instructor's progress reports for participating students

d. written examination

e. joint conference by hospital-college personnel.

Findings

The learning experiences provided were varied. They included:

Thorough orientation to the unit and to the central supply room where supplies for the operating room were prepared; demonstration and practice of specific procedures; guided reading and written assignments; surgical films; discussion periods for the sharing of experiences; oral presentation of individual study projects; attendance at special clinics (for example, cardiac catheterization) and conferences (for example, conferences for the surgical and anesthesiology staffs); observation of a variety of surgical procedures and of the patient in the postanesthetic recovery room; carefully selected and controlled participation as a member of the surgical team in the capacity of both "scrub" and "utility" nurse.

The learning experiences were placed in the curriculum at a time when the student had had a sufficient background of classroom and clinical experience to benefit from them (that is, subsequent to the initial introduction to nursing arts and general medical-surgical clinical experience). They were provided in a setting that was particularly conducive to learning because of the facilities available and the cooperation of the hospital personnel which made possible a flexible program capable of meeting the individual student's needs. In the instructor's opinion, the learning experiences were most effective in promoting the development of a degree of skill in functioning in the operating room and in stimulating assumption of responsibility for personal and professional growth by the students. They were least effective in helping students to gain a greater appreciation of the part that surgery plays in the plan of treatment for the patient, the provisions made for his welfare during surgery and the specific contributions made by the various members of the surgical team. This opinion was somewhat at variance with the one held by the students. Their consensus was that the experiences provided were, for the most part, adequate in assisting them toward the achievement of all of the objectives. While a longer period would have permitted the refinement of skill in functioning in the operating room this was not the primary aim of the experience in this particular program.

The majority of the students felt that actual participation as a member of the surgical team and the demonstration and practice periods were the most effective means of learning. All students expressed feelings of fear, anxiety and apprehension at the start of their experience. All excepting two gained a reasonable degree of self-confidence and satisfaction before the experience terminated. A majority of the students (10 out of 16) believed that it made possible the development of a degree of skill whereby they could return to the operating room as graduate nurses capable of applying the principles learned and able to proceed to the development of increased efficiency.

The most significant comments made by the supervisor and instructor in the cooperating agency at the joint evaluation conference were related to the students' apparent lack of fear, their development of self-confidence very early in the experience and their rather rapid adaptation to the situation. It was felt by the instructor responsible for the supervision of the students during this period that these factors might be attributed to the degree of responsibility that the students were encouraged to assume for their own learning; to the number of students supervised by one instructor; to the cooperation of

other personnel in making possible learning experiences that were meaningful to the individual student; and to the fact that the instructor, through her association with the students in previous clinical experiences, had some insight into their individual strengths and weaknesses and could therefore assess, with greater facility, their individual needs and capacities. The students also had the advantage of knowing how to work with this instructor most effectively and what they could expect, to a certain extent, in assistance and support from her.

The behavioral changes promoted by this experience appeared to be in harmony with the over-all objectives for the basic curriculum and the specific objectives for operating room experience.

Objectives of O.R. Experience

Objective I *To develop a greater appreciation of the part surgery plays in the plan of treatment for the patient and what this phase of treatment means to the patient.*

Related behavior:

1. Increased knowledge of a variety of surgical procedures
2. increased understanding of the relationship between specific surgical procedures and related pre- and postoperative nursing care including teaching
3. increased understanding of the relationship between the patient's history and symptoms and the choice and purpose of the particular surgical procedure elected
4. increased understanding of the emotional implications of this phase of treatment for the patient and his family
5. increased knowledge of the various anesthetic agents and their implication for nursing care in the postanesthetic recovery period.

Objective II *To acquire increased knowledge of the provisions made for the well-being of the patient during surgery and the immediate postoperative period.*

Related behavior:

1. Increased knowledge and understanding of the significance of the following: The physical set-up of the operating room and related units; housekeeping in the operating room; preparation and storage of supplies; positioning of the patient; safety precautions to prevent fire and explosion; safety precautions to prevent operative complications, e.g. hemorrhage, ruptured viscera, undue tissue trauma, burning, interference with nerve or blood supply, infection; precautions taken in the wise selection and use of anesthetic agents.
2. Increased understanding of the principles of surgical and medical asepsis as related to the welfare of the patient in surgery.
3. Increased knowledge of the precautions taken in the immediate postanesthesia period to safeguard the patient's welfare.

Objective III (A) *To develop an appreciation of the part played by each member of the surgical team in the total team contribution toward the patient's welfare.*

Related behavior:

1. Knowledge of the particular roles played by the various members of the surgical team and some comprehension of the knowledge and skills required to make each role effective.
2. Understanding of the interdependence of the roles of the various team members, the essential need for coordination of their activities and the kind of interpersonal relationships necessary to achieve such coordination.

Objective III (B) *To develop a degree of skill in contributing as a student nurse to the team's functioning for the welfare of the patient.*

Related behavior:

1. Ability to function as first or only scrub nurse in less complicated surgical procedures and as second scrub nurse in more complicated surgical procedures.
2. Ability to function as first or only utility nurse in less complicated surgical procedures and as second utility nurse in more complicated surgical procedures.
3. Ability to apply the principles of surgical and medical asepsis to avoid the introduction or transmission of infection in this situation.
4. Ability to assist with the preparation for surgery and the cleaning up and reassembling of the equipment in the operating rooms.
5. Ability to function cooperatively with other personnel in the surgical team through the establishment of good working relationships and the acceptance of responsibility for one's own contribution.

Objective IV *To further develop the ability to assume responsibility for*

personal and professional growth.
Related behavior:

1. A greater degree of development of the following personal attributes:
   - initiative to learn through self-direction
   - ability to function cooperatively with other personnel
   - self-confidence
   - acceptance of individual responsibility
   - ability to function in new situations
   - ability to cope with situations of "tension" and "pressure"
   - ability to make quick and sound judgment
   - ability to seek help judiciously and to use suggestions appropriately
   - control of emotional reactions
   - ability to derive satisfaction from participation in a clinical situation.
2. A greater degree of development of the following skills:
   - communication
   - observation
   - organization
   - use of available resources for learning
   - selection of meaningful learning experiences
   - identification of individual difficulties
   - finding satisfactory means of overcoming difficulties
   - problem-solving in order to meet the needs of a situation
   - application of knowledge and skills gained through previous experiences and synthesis of these with new knowledge and skills
   - critical thinking in the understanding of surgery performed and pathology discovered
   - control of bodily movements necessary for good manual dexterity
   - self-evaluation of performance with increased insight into personal strengths and weaknesses.

The methods of evaluation revealed definite opinions on the part of the instructor and students regarding the desirable behavioral changes that they believed the experience promoted. It was felt by the instructor, however, that these opinions were, in some respects, markedly subjective; that insufficient and inadequate criteria were used as the basis for evaluation; that insufficient evidence was produced by the instructor and the students, in some instances, to validate their statements. At the same time, it was recognized that where behavioral changes include the development of attitudes, understandings, appreciations and personal and professional growth in addition to the acquisition of specific knowledge and skills, no evaluation of achievement can be entirely objective either on the part of the observer (the instructor) or the participant (the student).

Conclusions and Recommendations

This four-week clinical experience was found to be worthwhile to the students from the standpoint of satisfactions derived and behavioral changes effected.

The learning experiences provided were varied and required individual and group effort on the part of the students. They were in keeping with the kinds of experiences provided in the other clinical areas in the curriculum.

The behavioral changes thought to be developed through this experience were in harmony with the overall objectives of the basic curriculum and the specific objectives of the operating room.

The limitations of the study were most marked in relation to the size of the group studied and the element of subjectivity in the evaluation measures used.

Subsequent to this study a course outline was prepared. It was used as part of the orientation for the operating room experience. It included an overview of the course; an outline of the specific objectives with related anticipated behavior; detailed instructions regarding projects to be undertaken during the experience, criteria to be used for self-evaluation.

A handbook of information related to specific procedures used in the particular operating room where the experience was obtained, was prepared to assist the student in adapting more quickly and to facilitate instruction in the time available.

It is suggested that another assessment similar to this study might be conducted on a more extensive basis with improved measures of evaluation and analysis. The behavioral changes that such a study might demonstrate could be evaluated by nurse educators who are contemplating either a modification or elimination of operating room clinical experience for students in the

basic nursing program. Such an evaluation might lead to the determination of whether any of the behavioral changes are unique to this area, whether they might be effected in other areas of the curriculum as effectively or whether it is preferable to retain this particular experience in order to continue to develop specific behavioral changes through it.

The Student Nurse and the Patient in the O.R.

NANCY BURWASH

The student nurse, as a member of the operating room team, has specific responsibilities to the patient.

ALL MEMBERS OF AN operating room group must work together so that the corps of workers may function not as individuals but as one unit having one common interest — the welfare of the patient. The main objective of the nurse on the team is to ensure maximum nursing care for the patient.

In order to give this type of care the nurse must be able to establish a good relationship with the patient. She should be ready to care for him as soon as he arrives in the operating room. She should accept the patient as an individual with fears and anxieties that are often exaggerated by illness. If he is awake the nurse should greet him courteously by his name. She should try and gain his confidence by short, precise explanations. Her warmth and acceptance of the patient's personal fears and physical needs, will help to allay anxiety.

The nurse should check the identity of the patient and the name of his surgeon. She should have the patient indicate where the surgery is to be performed, if one side is involved, and then make sure it coincides with the clinical diagnosis.

Miss Burwash is a student at the Montreal General Hospital.

After the patient's identity is confirmed the nurse should check his chart for a correctly signed consent form, his recorded temperature and if it is elevated notify the surgeon. She should note the preoperative medication, physical preparation, preoperative urinalysis, religion and history.

If the chart is satisfactory, the patient is moved to the operating table. His head is covered with a cap, his gown loosened, and the knee strap secured. A brief explanation of this procedure is given and then he is moved into the theatre. The nurse should remain with the patient until he is anesthetized — under no circumstances should she leave him alone.

Posturing the patient is also a responsibility of the nurse. She should maintain good body alignment, avoid any accidental injury, minimize discomfort and maintain the dignity of the patient at all times.

The operating room nurse must observe aseptic technique. If there is a break in this technique it should be remedied at once.

For the operating room nurse to fulfil all these responsibilities to the patient, she must have a keen sense of duty, be dependable and above all, be exceedingly conscientious.

The Poultry Products Institute tells us that many consumers still do not realize that although they buy them by the dozen, eggs are actually sold by weight. A dozen grade A large eggs weigh a minimum of 24 ounces (1½ lbs.), grade A medium weigh 21 ounces (1 lb. 5 oz.) and grade A small weigh 18 ounces (1 lb. 2 oz.).

OPERATING ROOM TECHNICIANS

SUMI IWAMOTO

Scrubbing for operations has been regarded as a skilled technical procedure. The trend today is to consider the professional aspect of operating room nursing as the function of the circulating nurse.

THE FIRST CLASS of operating room trainees at the Toronto General Hospital was formed in 1957 to assist the nursing personnel. The objectives of the course are to teach the trainees to scrub for operations and to assist the nurses with other duties in the operating room.

Applicants do not necessarily have to have previous hospital experience. They must be between 18 and 35 years of age, in good health and have at least grade ten education. Many of the present technicians were former ward helpers with excellent recommendations from their supervisors. Applicants are interviewed by the assistant director of nursing service and by the operating room supervisor or instructor. Most of the classes average four trainees in number.

During the three months' course, the students live out and receive a monthly allowance. Their uniforms are laundered free of charge. They work a 40-hour week on day duty. The operating room instructor and head nurses take the responsibility for the teaching program. Each trainee is interviewed and her progress evaluated at the end of the first month. The interim report and the final one are sent to the director of nursing.

Lectures and demonstrations total 55 hours. There is a daily review of theory and individual return demonstrations of procedures. When the technicians are assigned to scrub at the end of two months, they have learned hospital ethics, theoretical principles pertaining to the operating room and possess a knowledge of various basic procedures. They also receive instruction in anatomy to permit intelligent scrubbing. Preparation of operating room supplies is made familiar to them by specified work periods in the Central Supply Service department which takes care of all sterile operating room supplies.

The trainees begin their practical experience by setting up the instrument tables. Later they scrub for minor operations and finally for major ones. They are given oral, written and demonstration tests at the conclusion of their course. The pass mark is 60 per cent.

Applicants are told during the initial interview that their training is to adapt them to the operating room and that they will be appointed to the staff when they successfully pass the final tests. Three weeks' annual vacation and a salary schedule are provided in the personnel policies.

The operating room technicians do not administer drugs or take the responsibility for sponge counts. They are never left in charge of an operating room. Skillful and experienced as they may become, they do not assume any responsibility for teaching student nurses. Their goal is to become capable of scrubbing for any type of operation.

As trainees, they are usually very enthusiastic and eager to learn. They have proven to be excellent scrub personnel; have fitted smoothly into the pattern of operating room teamwork on all tours of duty and have been well received by both surgical and nursing staff. Another rewarding aspect of the use of operating room technicians has been their stability as staff members.

Miss Iwamoto is a member of the operating room staff, Toronto General Hospital.

It is understood that one or two enlightened cereal manufacturers will in future pack the free gifts in the packet, with a coupon to be sent in by customers who want the cereal.

— *Punch*

Clinical Landmarks in Alcohol Addiction

R. G. Bell, M.D.

The development of alcohol addiction is such a subtle process that the afflicted individual may not be fully aware of what is happening until too late.

The word "addiction" has come to mean many different things to many different people. Those engaged in the clinical management of addiction can agree on at least one point. It is a complex human disability that cannot be described easily in a few words.

Usually, a physician has clinical "landmarks" which assist in his orientation to a particular disease. These enable him to visualize the various aspects of the disease process and permit him to estimate the duration of the illness, the method of treatment, prognosis, and so on.

For the purposes of this discussion, addiction is simply defined as a harmful dependence upon one or more chemicals. The nature of the "harm" produced by addiction will vary with the chemical involved. For example, food and tobacco addiction can produce significant physical changes but few important mental or social changes. Since addictions of this type do not produce a socially undesirable change in behavior, they are not regarded as particularly threatening to the community as a whole. On the other hand, addiction to alcohol, barbiturates and tranquillizers can produce serious changes in all three areas — physical, mental and social. There are many reasons for this, but two stand out. First, these chemicals can so affect the brain as to produce the phenomenon of "drunkenness." Drunken behavior is unacceptable in most communities. Secondly, with addiction to alcohol, "drinking" eventually *replaces* other activities in the home, on the job, in the community, in contrast to addiction to tobacco in which "smoking" is *superimposed upon* these other activities without replacing them.

This discussion supports the thesis that an addiction should be examined from nine different standpoints: the physical, psychological and social situations existing prior to the beginning of a harmful dependence; the physical, mental and social changes arising out of a harmful dependence; and the physical, mental and social situations after the harmful dependence has been discontinued. With this orientation, the accompanying chart should be self-explanatory. An attempt has been made to indicate the physical, mental and social status before, during and after alcohol addiction.

The following features of the chart are considered worthy of special mention:

A. The Physical Sequence

1. *Before*

A certain physical state must be present to permit alcohol addiction to develop. Thus, the person who is incapable of enjoying any welcome effect from alcohol, regardless of dose, will not become addicted to alcohol

2. *During*

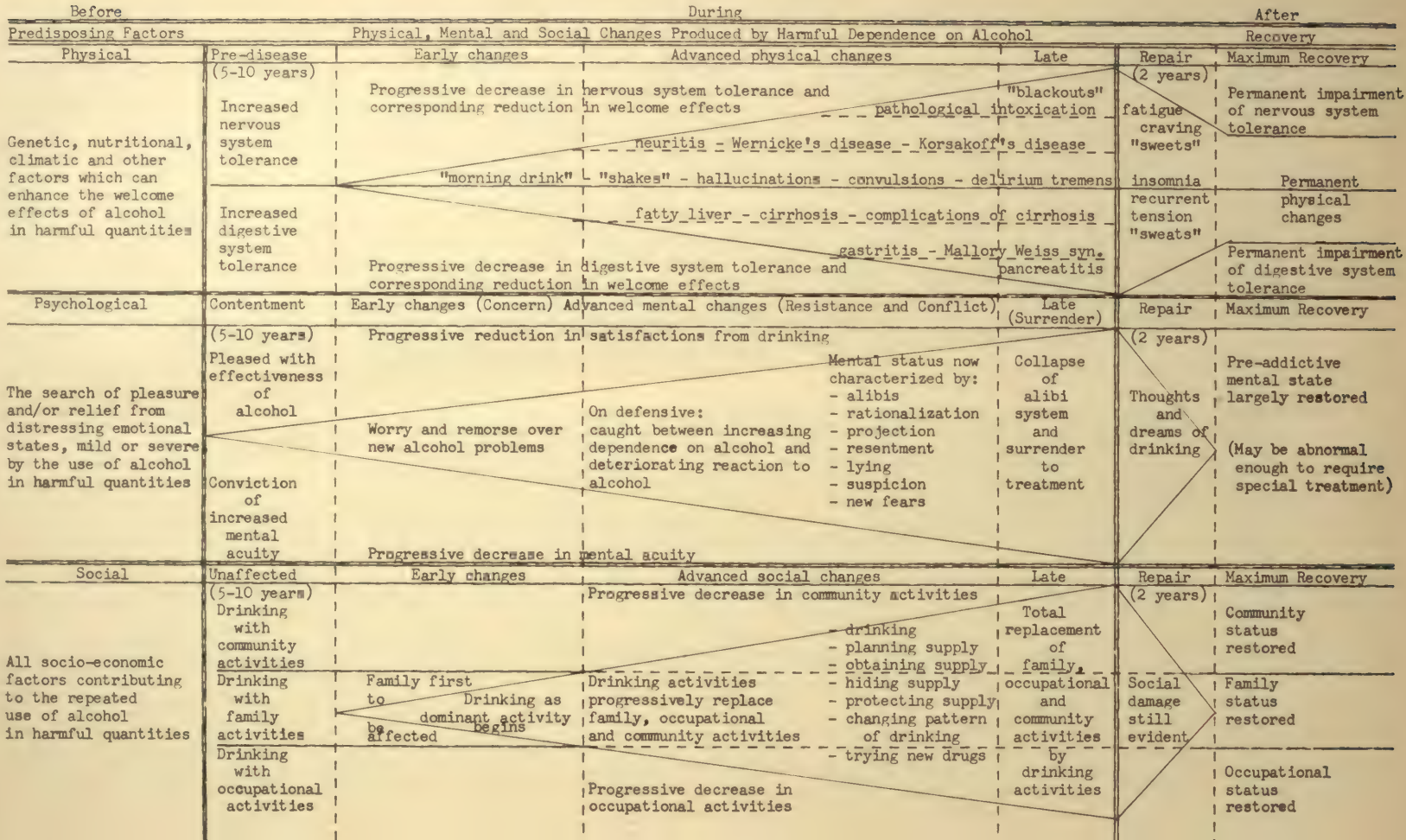
All of the significant physical abnormalities arising out of a harmful dependence upon alcohol occur in either the nervous system or the digestive system. Most of these changes are permanent rather than temporary, for example, those responsible for withdrawal reaction, pathological intoxication, cirrhosis, Wernicke-Korsakoff syndrome. Accordingly, the symptoms of these abnormalities indicate a permanent intolerance for alcohol.

Drinking may be either continuous or sporadic — "chronic or bout." The change from chronic to bout drinking usually represents a break in nervous system or digestive system tolerance — rather than a new psychological phenomenon. In other words, the alcohol addict usually continues to drink regularly as long as his brain or stomach can stand it.

The "blackouts" are deliberately represented as a manifestation of a late rather than an early physical change.

Dr. Bell is the medical director of The Bell Clinic, Willowdale, Ont.

ALCOHOL ADDICTION
(A harmful dependence on alcohol)



Actually, they may occur either early or late in the addiction experience. Too many people automatically associate drunkenness with alcohol addiction. However, when alcohol addiction is recognized at an early age, it is usually because drunkenness and "blackouts" do occur as an early manifestation of a harmful dependence on alcohol. A harmful dependence upon alcohol can be maintained for years without obvious impairment in physical or social status. In such cases, practically the only indication of a significant physical change would be the need for the "morning drink."

3. *After*

The chart indicates that a period of physical repair of approximately two years' duration is consistently indicated, regardless of the combination of physical changes in a particular case. Some of the symptoms experienced during this period are indicated, plus the fact that maximum recovery falls far short of anything that would permit a return to normal tolerance.

B. The Psychological Sequence

1. *Before*

It is important to emphasize that both the search for pleasure and the relief from distressing emotional states can provide the psychological component of the "seed-bed" for alcohol addiction. The distressing emotional states can vary from those considered too mild to be of clinical significance by themselves to the grossly distressing emotional states of severe neurosis or psychosis.

2. *During*

An attempt has been made to indicate that the satisfactory experience of drinking introduces a new element into the thought and emotional life of the patient. The new mental activities concerned with the use of alcohol begin to modify the personality of the drinker, particularly when he begins to be in trouble because of a breakdown in tolerance or in social approval. Eventually, alcohol addicts begin to resemble one another because of the similarity of the thought patterns that accompany later stages of alcohol addiction. This means that the pre-addictive mental state becomes "blurred" and finally "covered over" by the thinking arising out of the addiction.

On the chart, the alcohol addict eventually achieves a "phase of surrender" in which there is a collapse of his alibi system and a willingness to accept help. Prior to this development, he goes through a long period during which he attempts to hold on to his addiction with one hand and his family, occupational and community position with the other.

I am personally convinced that only a small minority of the alcohol addict population resolve this conflict in the manner indicated on the chart. I am also convinced that the great majority of alcohol addicts either die prematurely by suicide or other causes while the conflict is still being actively engaged, or that they surrender completely to the addiction like the "skid row" habitué. The tragedy is that most of these people could be successfully treated if they could be freed from the self-perpetuating mental mechanisms of the phase of "resistance and conflict."

3. *After*

The chart indicates that the reappearance of the pre-addictive mental state during recovery may reveal the presence of long-standing psychological problems sufficiently abnormal to require special treatment.

C. The Social Sequence

1. *Before*

Many communities have established drinking patterns involving the repeated use of alcohol in harmful quantities. A harmful dependence upon alcohol can be more readily developed in such a setting.

2. *During*

It is important to emphasize that very frequently a family can be practically destroyed without any apparent change in the community and occupational situation. It is also important to realize that absenteeism, as a result of a harmful dependence on alcohol, is practically never an early indication of alcohol addiction.

3. *After*

The chart indicates complete repair of the social changes in the two-year period. This is the ideal state. It is possible only if the addiction has been interrupted before gross social changes have occurred. Many family and work situations have been so completely broken up as a result of a dependence

upon alcohol as to be irreparable. Thus, in any particular case, there could be a residue of permanent social changes as well as a residue of permanent physical changes.

Conclusion

It is the responsibility of the physician to explain alcohol addiction clearly to those who are dependent upon alcohol. The industrial physician, rather than the foreman or the supervisor, must assume the responsibility for early recognition of alcohol addiction in the industrial setting. If the physician assumes the same attitude towards the investigation and the treatment of the victims of addiction as he does to the victims of infection, the community as a whole will follow his lead toward more effective solutions to these complicated disabilities.

The Nurse and the Alcoholic

Alcoholism is a disease. The alcoholic must first accept the fact that he needs treatment before he can be treated effectively. Those who care for him must understand him and the nature of his disease to be truly helpful.

ALCOHOLISM IS A DISEASE manifested by acute or chronic excessive indulgence in alcoholic beverages. The definition used by Alcoholics Anonymous is "a progressive illness which can never be cured, but which can be arrested." It represents a combination of physical sensitivity to alcohol and a mental obsession to drink. Regardless of consequences this cannot be broken by will power alone. Most definitions do concede that alcoholism is a disease. It differs from other diseases in many ways. This was pointed out in an article in *The Canadian Journal of Public Health,* September 1957:

> In what way is alcoholism different from other illnesses? To begin with, there is no textbook definition of etiology or of treatment; there are no wonder drugs and no sure controls; there is no well-defined pain or diseased area, and the course of the disease shows about as many variations as there are patients. The alcoholic is sick socially, economically, and spiritually, long before there are any chronic physical conditions. Like the diabetic, he is up and around, except in the acute phases, often carrying on successfully at home and in business, but with one significant difference that for many years he refuses to recognize and to admit to ill-health. He must often lose family, friends and job before he accepts the need for treatment. In what other illness are there so many unpredictable relapses? In what other illness must the patient, in order to get well, give up the one anesthetic which can dull the pain of his suffering?

In Ontario, approximately three per cent of the drinking population become alcoholics. In 1956 there were 76,000 alcoholics in Ontario, 182,000 in Canada. The average alcoholic in Ontario, still has his job, home, and family. One in every six Canadian alcoholics is a woman.

A "problem drinker" is one who persists in repeated excessive intake of alcohol, with little regard for the effect on his family, job, finances or physical well-being. When a "problem drinker" loses control of when he drinks, how much he drinks, and how long a drinking episode lasts, he is an alcoholic.

The precise etiology of alcoholism is unknown. Psychological factors play an important part. Subconscious feelings of insecurity, inadequacy, conflict, guilt, and frustrations may contribute to the disease. Social drinkers may become alcoholics, if social drinks increase in number and frequency. In the business

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This material was prepared by a small group of students during their experience in the medical department in the first year of their program at The Atkinson School of Nursing, Toronto Western Hospital, Toronto, Ontario.

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Walter, C. W., and Errera, D. W.: Hospital Topics 38:93, March 1960.

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world a drink "to top off a big deal" may become a necessity.

In some instances alcohol serves as a crutch in the relief of tension. One generation ago it was thought that only weak individuals, or those of defective character would become alcoholics. Today it is realized that alcoholism occurs among all types of people — doctors, businessmen and women, clerks, school teachers, actors, lawyers, skilled workmen, laborers, ne'er-do-wells, and criminals. They do not all lack intelligence, character, responsibility or awareness of moral and ethical standards. Alcoholism may result from an unhappy childhood experience, an over-protective mother; be initiated by a thwarted marriage or by innumerable failures. Alcohol is not the basic cause. In summing up, the causes could be related to: certain types of personalities, plus certain situations, plus alcohol in excess.

The Effects of Alcohol

The liver can oxidize about as much alcohol in an hour as is contained in a highball or a pint of beer. Excess alcohol — the second highball or pint of beer consumed in the hour — circulates in the blood stream until the liver is ready to oxidize it. The following table* shows the effects of the excess alcohol in the blood stream:

less than 1 mg. alcohol in blood — person is dry and decent
1 - 2 mg. — delighted and devilish
2 - 3 mg. — delinquent and disgusting
3 - 4 mg. — dizzy and delirious
4 - 5 mg. — dazed and dejected
more than 5 mg. — dead drunk.

Alcohol acts first as a stimulant and later as a depressant. It is a tension-reliever. It helps to obliterate self-consciousness. The person may have a new but false feeling of security. It creates a temporary elimination of family and business worries. It initiates feelings of superiority and grandeur. Uncontrolled drinking may lead to attainment of many friends, but friends of no import. Alcohol arouses false courage, and is a satisfying flight from reality. Later, when the person becomes an alcoholic, alcohol relieves the craving sensation.

On the other hand, alcohol decreases coordination and slows down physical activity, especially in undertakings requiring skill. Memory, learning, thinking, and reasoning are impaired. Judgment is decreased. Attention and concentration are reduced. It may produce temporary depression. With time, real friends are lost. There may be a family crisis. The person may be involved in automobile accidents or thefts. There may be a loss of self-respect, and a disregard for honesty, or a fear of society other than fellow-drinkers. A vicious circle develops — loss of job, high liquor bills and debts produce more worries, which lead to more drinking. The person may even have suicidal ideas. Prolonged use of alcohol leads to the inability to stop drinking — the major symptom of alcoholism.

Following a bout of excess alcohol intake, the person may experience acute gastroenteritis. If prolonged he may develop a peripheral neuritis or loss of motor control. With the accompanying poor diet avitaminosis develops and degenerative processes occur in the liver leading to cirrhosis.

Some patients appear in the medical wards of hospitals with delirium tremens. This is a psychic disorder due to the effect of alcohol, and is precipitated by sudden withdrawal, or by stress such as infection. It is manifested by hallucinations, both auditory and visual. The person may see snakes, monsters or fire, and may be talking or shouting incoherently. He may carry out actions for which he is not responsible. Tact and skill are necessary at this time. Argument is useless for he is beyond reason.

Treatment

Stop all alcohol. Sedatives such as Sparine, bromides, or paraldehyde may relieve withdrawal symptoms. Some alcoholics are carried through the acute phase with the aid of insulin. Gastric lavage to dispose of unabsorbed alcohol may be necessary. A bland diet, including large doses of vitamins and fluids, should be started as soon as the person is able to take nourishment. Sleep is important. There must be protection of the patient against suicide or self-harm which may result from

*Muncie, W. Psychobiology and Psychiatry. C. V. Mosby Company, St. Louis: 1948. Page 54.



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confusion and disorientation, or from a desire to escape. In long-term management the drug Antabuse, may be used to produce vomiting if alcohol is consumed.

The nurse frequently comes in contact with the alcoholic in the hospital. Her attitude towards the patient is important. She must look for the real personality of the person she is nursing. She must try to accept and to understand that the untruthfulness, the broken promises, and the need to continue on the path to self-destruction, are just as symptomatic of this condition as the excessive consumption of alcohol. She must try to accept the fact that the alcoholic, although an adult, is a dependent person. Although his attitude, at times, tries the nurse's patience and tolerance, she must seek to cope with this. She must learn to accept the alcoholic's inability to bear responsibility, his tendency to give up easily, his denial of help, his belittling of dependency on others, his jealousy, his impulsiveness, his reaction to authority, his over-talkativeness, his demanding attitude and his need to project blame on others.

Patients with alcoholism need consistent care, but should not be treated like children. The nurse should be firm but flexible. She must help the patient face reality, and help him realize that he must start a new way of life if he wishes to recover.

It is not easy for a person to nurse alcoholics, if pre-formed attitudes conflict with what she is attempting to tolerate and understand. The nurse must think carefully about her feelings and opinions in regard to alcoholism, and read information on the subject to aid in this. She must then feel a sincere desire to help the patient, and make a real attempt to understand his underlying character and his actions. Her care must not only continue during the acute stage, but extend into the period of rehabilitation.

Aid for Alcoholics

Aid comes from many sources: physicians; clergy; public health nurses and social workers; psychiatrists; Alcoholics Anonymous; Alcoholism Research Foundation.

Alcoholics Anonymous is a group of people for whom alcohol has become a major problem and who, by admitting this, have decided to make an honest attempt to build a satisfactory mode of living without alcohol in any form. The only requirement for membership is an honest desire to stop drinking.

The Alcoholism Research Foundation, an independent organization set up by the Ontario Government, conducts scientific research to help find the answers to problems connected with the use of alcohol and alcoholism. It provides pamphlets for the public, alcoholics, and problem drinkers. Clinics for treatment of the alcoholic are set up under its supervision. Treatment and aid are closely related and can only be effectively carried out by cooperation between professional men and women, the above agencies, the public, and the alcoholic himself.

For many years alcoholism was considered a disgrace, a misdemeanor, not an illness. The alcoholic's behavior was thought to be humorous. People were ashamed to seek treatment for their illness and to discuss their condition with others who wished to help. This attitude still persists to a great extent, even though much has been done in the way of public education to break down the barrier to successful control of this disease, and to bring into light the facts about alcoholism.

One way the nurse can contribute to public education is by giving thoughtful interpretation of institutional treatment to alcoholics, their friends, and their families. This will help to establish new attitudes towards this illness, and pave the way for more effective treatment of alcoholism in the future.

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* * *

How we steer our course during the day's first hour is important for all of the other hours.

He who will not reason, is a bigot; he who cannot is a fool; and he who dares not is a slave. — Sir William Drummond

* * *

Character is what you are in the dark. — Dwight L. Moody

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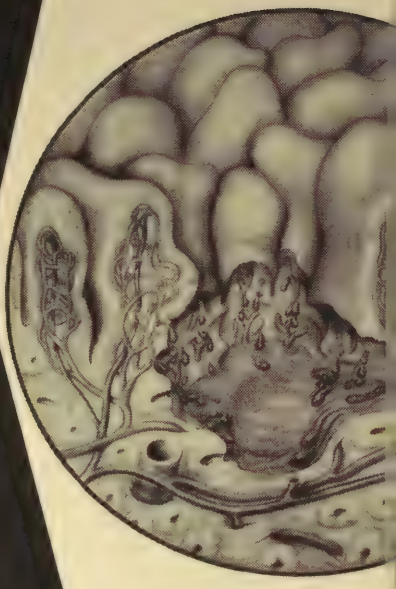
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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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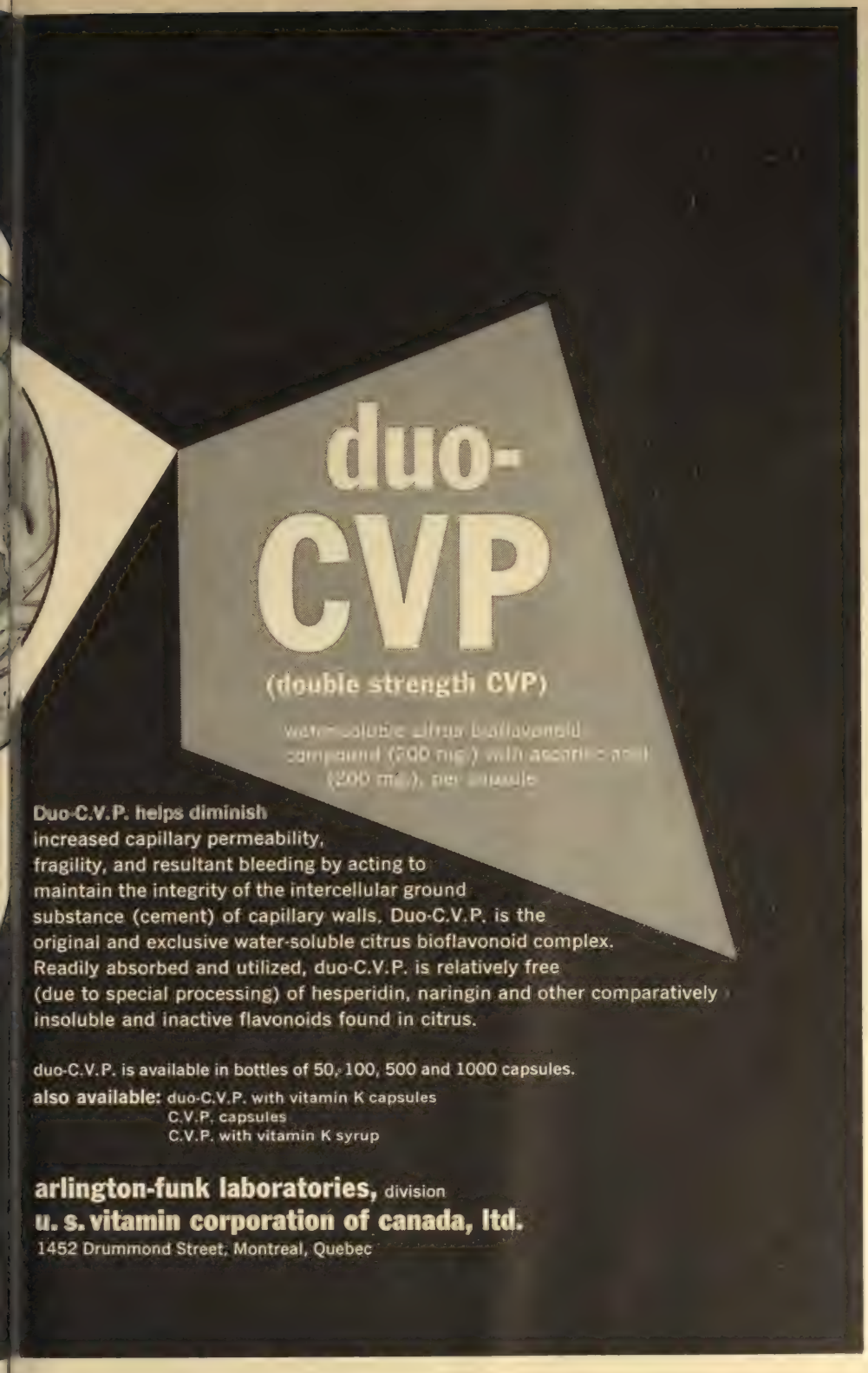
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NURSING PROFILES

The appointment of **Marjorie L. Wenger** as editor of the *International Nursing Review* was recently announced by the International Council of Nurses. Prior to taking over her present duties, Miss Wenger had been editor of *Nursing Times* for the past 12 years.

A graduate of Middlesex Hospital, London, England and with her qualifications as a sister tutor, she became principal tutor of her school of nursing in 1941. Later she served as an examiner for the General Nursing Council for England and Wales and took particular interest in professional organization especially in the field of nursing education. As a nurse journalist, and then as editor of *Nursing Times*, she travelled extensively visiting schools of nursing, health centres and occupational health services; attending conferences and congresses in cities as widely separated as Atlantic City and Stockholm, Rio de Janeiro and Rome. She is no stranger to Canada and many of our nurses may recall meeting her at the 50th anniversary convention of the CNA in 1958.

Our warm good wishes and heartiest congratulations are extended to Miss Wenger.

The appointment of **Betty Louise Sellers** as director of nursing service, University Hospital, Saskatoon became effective in mid-June. A graduate of the Regina General Hospital in 1950, Miss Sellers completed requirement for her bachelor of science degree in nursing earlier this year. For the past five years, she has been associated with University Hospital as supervisor of the central supply service, operating room supervisor and more recently as assistant director of nursing service.

Miss Sellers succeeds **Kathleen Ruane** who recently resigned from University Hospital to become the coordinator of an educational program for nurses sponsored by the CNA and CHA.



BETTY LOUISE SELLERS



MARIE E. HUDSON

Marie E. Hudson has been appointed director of nursing of Joseph Brant Memorial Hospital, Burlington, Ont. Miss Hudson, who is a graduate of the General Hospital, Rochester, N.Y. and of Columbia University, New York, was assistant professor of the school of nursing, University of Western Ontario, London immediately prior to this appointment.

She has had considerable experience in the field of nursing administration, having served as director of nursing at Hamilton General Hospital 1953-59 and in the same capacity at Syracuse University Hospital and Rochester General Hospital. She is also a former director of the Hamilton branch of the Victorian Order of Nurses.

The Joseph Brant Memorial Hospital is presently under construction with the of-

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ficial opening scheduled for early 1961. The position of director of nursing of it will present fresh and exciting experiences.



E. Jean McKay

The Toronto General Hospital has announced several changes in senior staff positions. **E. Jean McKay** has assumed the duties of assistant director, staff education. This is a newly-created position and Miss McKay will be responsible for organizing and directing the inservice program for professional and auxiliary nursing personnel. She is a T.G.H. graduate with her B.Sc.N. from the University of Western Ontario. Until recently she was assistant director of nursing service at T.G.H.



(C. L. Milne Studios)

M. Jean Dodds

Margaret Jean Dodds is the new assistant director of nursing service. A 1946 graduate of T.G.H., she took postgraduate study in nursing education at the University of Western Ontario. She has had much experience in supervision and teaching, as operating room supervisor and instructor 1951-58, and for the past two years as nursing service supervisor in the Central and Gerrard Street buildings.



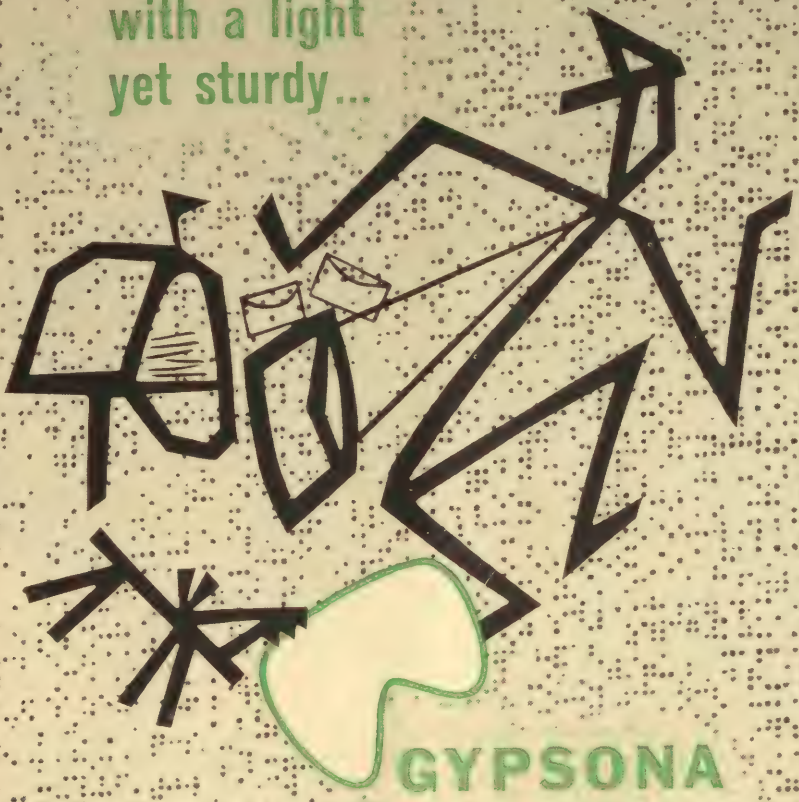
(Victor Aziz)

Kathleen Pitts

Kathleen Christine Pitts has been named nursing service supervisor, Central Building, T.G.H. A graduate of the Ontario Hospital, London, she studied nursing administration at the University of Western Ontario. Miss Pitts has been on the staff of the hospital for several years in head nurse and supervisory capacities.

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WHY STATISTICS?

MARGARET CAMPBELL, M.P.H.

This is a discussion of the purpose and content of a course in statistics for graduate nurses.

STATISTICS AS A SUBJECT offers a real challenge to some of us, while others are bored or intimidated by the very mention of the word. The latter group likely confuses the facts with the science. Statistics involves two definitions — the numerically stated facts, and the methods of collection, treatment and presentation of these facts. When you consider that the science of statistics had its origin, not in a sterile, thought-provoking atmosphere, but in the gambling halls of Italy, the subject takes on unique color and fascination. It was Galileo who, in the 17th century, prepared his classic treatise on dice to assist his gambling friends in placing their wagers. From this grew the science that enables man to measure, calculate, deduce and ultimately to solve, some of the mysteries of the universe. But no mysteries can be solved without a lively and intelligent interest in the subject.

As thinking people, we deem ourselves capable of separating opinion from fact, of distinguishing associated factors from true causes. Every day, we have countless opportunities to test our ability to do this. We are surrounded with surveys and studies, with collections of quantitative data and interpretations of them. Look at the daily newspaper. In one issue, we may note such items as the state of the federal budget to date this year compared with this date last year; the current number of unemployed and an interpretation of the reasons for its rise or fall; the latest cost of living index and the factors which have made it so; the fraction of adults in a sample who say they will vote for a particular party in a coming election; and data which attempt to relate smoking habits to the incidence of lung cancer, or blood grouping to the incidence of certain pathological conditions. The list is endless and it is taken from only one of the sources of numerical information to which all of us are exposed.

In addition, we encounter data specifically directed to nursing audiences. We are expected to be well-enough informed to react to such data with some degree of critical judgment. Moreover, as a profession, our interests are being increasingly channeled toward research in the nursing field. Therefore, some of our members must be prepared to carry responsibility for such projects with judgment, integrity, and in strict accord with the scientific method. Is it not logical to expect that those nurses who are striving for preparation beyond hospital graduation should be provided with the approach and the tools? This is the group from whom leadership is expected in nursing.

There is no doubt that statistics as a field of endeavor deserves serious study in its own right. The purpose here is to encourage an active interest and alert attitude toward statistics — both the data and the methods of handling them — and to give some basic principles that will help the student to extract truths from veritable forests of facts.

Experience indicates that the majority of nurses who do or should take courses in statistics, are not equipped to pursue a very advanced mathematical approach. Indeed, some have the most acute difficulty with simple fractions, to say nothing of rates and percentages. Even averages and other measures of central tendency have no real meaning. The concept of the laws of probability is most novel and difficult for many students. "Trusting to luck" or accepting someone else's deliberations as to the odds has been their habit, which has permitted them to

Miss Campbell is assistant professor in the school of nursing, University of Alberta, Edmonton.

This paper was presented at the Conference of Learned Societies, University of Saskatchewan, June 1959.

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We find ourselves faced with the tasks of preparing material that will be comprehensible and useful for students with varying abilities in mathematics, logic and the use of common sense and of presenting it in a concise and interesting way. To accomplish this with any degree of success, the material must be reduced to the simplest terms and closely tied to familiar data. By taking certain raw data from our health bookkeeping — biostatistics — which already has some element of familiarity for the student, and demonstrating certain techniques that render this data suitable for analysis, interpretation and comparison, even rates can take on a fresh, exciting meaning. We indicate the strengths and weaknesses of certain data because some of the most commonly-used rates defy the rules of logic and endure merely for tradition or convenience. This material serves to introduce methods of presenting data and emphasis is on the integrity of the producer of statistics. Certainly, it is commendable to present findings in the most conclusive and convincing manner possible, pointing out and emphasizing the various facts they indicate. But the producer has equal responsibility to confine her conclusions within the limits of her data. She should not cloak, eliminate, neglect to gather nor otherwise twist her information so that the consumer is hoodwinked into accepting an illegitimate conclusion. From the point of view of the consumer, she must have sufficient background to be able to evaluate the offering and decide for herself what to accept and what to reject.

In presenting examples of studies for evaluation, it is unfortunately true that those illustrating *misuse* of statistical methods are more readily found than logical, cautious, well-thought-out studies. However, an excellent and fairly simple example of the latter has to do with the Salk vaccine trials. This study illustrates, in a particularly fine manner, the careful planning down to the most minute detail that was carried out by a group of highly skilled practical people, before a single syringe was lifted. It points out, in a constructive way, that there is more to solving a problem than merely hatching an idea and hoping for the best.

Examples of misuses of statistics surround us. Books have been written on how to lie with statistics. Disraeli must have been exposed to some of this material when he deducted that there are "lies, damned lies, and statistics" in increasing order of magnitude. There is no shortage of illogical, opinion-swaying literature being published in the name of scientific investigation. As a rule, it illustrates the unintentional and thus less vicious type of misuse. Perhaps simple lack of thought in the planning stage of the study or illogical reasoning in analysis of the findings is shown. Nevertheless, this is as misleading as the flagrant, deliberate misuse of statistics with ulterior motive.

In summing up, in the study of statistics emphasis should be placed on reason and common sense rather than mathematical computation. Reason and common sense point out to the student the limit of her knowledge and the areas where more expert help should be secured. It may be in determining size and selection of a sample; the relative weight of a number of factors influencing a result; the significance of an observed difference; the limits of probability regarding the reliability of an interpretation. All may be considerations in studies done by nurses. Students must be better equipped to evaluate studies done by others in order to help to raise the standard of nursing research.

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RUTH M. MORRISON, M.A.

The group project can be an effective means of teaching and learning.

SOME YEARS AGO A public health nurse friend was coming to spend the weekend with me in my very small apartment. She wrote to say that she had acquired a dog; that she hoped dogs were permitted in the block I lived in; that his name was Caesar Montmorency and would I buy two pounds of hamburger and two beef kidneys since the shops might be closed when she arrived.

Now I, too, had a dog — a smooth-haired fox terrier — and an indulgent landlord who permitted me to keep her provided that she was well behaved, but a second one, and obviously a big one, was quite another matter. So I sought help from a friend who had a large dog of his own and plenty of space. He agreed to provided sleeping accommodation for Caesar Montmorency and my mind was considerably relieved.

On Saturday at 6:30 P.M. a car horn honked and I went out to greet my visitor. She emerged from the car with a suitcase in one hand and a small picnic basket in the other. She handed me the basket saying, "Handle it with care. It contains the sweetest and smallest dog in the world with the largest name."

There is a moral to this little story. The pretentious title of this article may have led you to expect an involved and erudite exposition. On the contrary I simply want to tell you about one teaching method that I have been using for a few years.

May I make two observations?

1. The university does not expect to provide students with all of the answers, but it does expect to increase their ability to ask questions and to learn how to find answers.

2. The practice of public health nursing changes rapidly and the graduates of our schools need to know how to keep up with the changes.

Students tell us, "We want more time to think and reflect." They also tell us they want the benefit of our knowledge. Our curricula are crowded. There is so much to learn and so little time. It is a constant struggle to strike a balance in our programs between "telling" and "guiding." The educational program that is overloaded with facts poured out by teachers is acceptable to none of us. The one in which the faculty turn back all of the responsibility to the students leaves them frustrated and rebellious.

How *do* we "prepare learners to make progressively effective adjustments to a swiftly changing society."[1] How *do* we meet the obligation to provide future practitioners with sufficient factual public health knowledge to begin their careers, and at the same time, equip them with tools of self-direction that will make them capable of continuous growth and professional development so that they can help society to meet its needs. Dr. Mursell has said that

> learning should be organized in terms of understandings which:
>
> 1. seem real, compelling and valuable *to the learners,*
> 2. engage them in active purpose,
> 3. confront them with a significant challenge, and
> 4. lead them to deeper and wider insight, more discriminating attitudes, and more adequate skills.

With all these thoughts in mind I examined the content of the course in principles and practice of public health nursing and selected some topics for special study by groups of students. The purpose was to give the students an opportunity to:

1. Delve more deeply into one phase of public health nursing practice than

---

Miss Morrison, an associate professor in public health nursing at the University of British Columbia and president of the Canadian Conference of University Schools of Nursing, presented this paper at the Conference of Learned Societies held last summer at the University of Saskatchewan.

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they otherwise could, through reading, discussion and interviews,

2. participate in a group project similar to those that they will encounter as practitioners,

3. have additional teaching experience.

At the beginning of the term the students are given a list of topics and, whenever possible, they elect the one they want. The groups should be approximately the same size and are arranged by the students themselves.

I meet with each group for the first few times. Some only want my assistance once or twice, to help them to organize. Each group appoints a leader, a recorder, a librarian and a publicity representative. In some groups these persons function throughout the whole project, others alternate the responsibilities. In addition each group appoints two persons to learn to use a projector. When our enrollment was smaller all students had instruction and practice in this. We have to limit it now to selected students and they, quite frequently, teach it to others.

Some of the topics studied have been: Alcoholism and narcotism, home safety, gerontology, prepaid health care plans and handicapping conditions in children. The assignment is given in terms of public health nursing practice. Thus nursing is always stressed and, where applicable, the mental health and rehabilitation aspects are included.

The groups arrange their own times for meetings, methods of research and interviews with resource people. They prepare objectives and design forms for the evaluation of their own learning and of their teaching. They also plan the method of presentation to the entire class. This is an important feature for they know that all of the other students are depending on them for material on which they will be examined, just as they are depending on the other groups. In conference with the instructor they manage to use a suitable variety of teaching methods, and as you would expect, they make some highly original applications of the methods.

Each group meets with me at intervals to check their progress. They are free to proceed at their own pace and in their own way. The only control I insisted upon is that they confer with me before writing, telephoning or visiting people in the community. This is to avoid any one person or agency being troubled too frequently. Sometimes a more suitable person whom they might approach is suggested. Occasionally the first contact, for example with the Chief of Police, or the head of a correctional institution, is made from the office just to keep our "public relations" in order.

A conference with the leaders is held to decide on the dates of the presentations to the class and any other matters that affect the time-table or general program. All of the presentations are given in the last six weeks of the term. Guests may be invited to participate, but not to give a lecture. Since each group has only a two-hour period for the actual presentation they do a great deal of advance publicity through posters, clippings, cartoons, spot announcements in class, scrapbooks, and various other features. Following each oral presentation a written report of the whole project is submitted and is immediately made available in the reading room.

The requirements include keeping a bibliography file from the current magazines up-to-date for each topic. At the end of the term they select the most valuable of these and add references from books, films, pamphlets and reports. These lists are mimeographed and given to every student in the class for future use.

The final group meeting with the instructor is for evaluation purposes. The amount of insight gained not only into the subject but into the reactions and behavior of the group and of each individual member is always amazing.

Some indication of how students who participated in interest groups have been motivated to use the knowledge gained, and to adjust to new situations is evidenced by the following:

One person submitted a paper to the Scientific Papers committee of the Canadian Public Health Association 1958 meeting, on alcoholism and narcotism and its relation to public health nursing practice.

One entire group has continued to hold meetings since 1956 and to work with the Vancouver Safety Council.

Several students have organized discussion groups in their health units with staff, and with lay people.

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One group, which made a movie and another which took an excellent series of color slides as part of their project, have a system whereby any of the students in those two classes may use them in their communities.

One graduate was able to overcome strong community objection to fluoridation by using the interest group method. The town now drinks fluoridated water.

Former students also tell us that they feel that they are able to fit into the health team with greater ease; that they appreciate being able to make a special contribution in an area that they have explored fully. They find too that this method stimulates them to seek solutions to problems and not to be satisfied with merely superficial knowledge.

This learning technique appears to embrace several characteristics of sound education. It provides context, focus, and socialization. It encourages organic integration and evaluation. It permits interaction between learners and resource people in the community, and the audience to whom they present their findings. It provides stimulation and results in depth of learning in at least one aspect of public health nursing practice.

In the Good Old Days

(The Canadian Nurse — AUGUST, 1920)

The custom of giving a dose of castor oil the second or third morning of the baby's life is in most cases unnecessary, as the colostrum acts as a laxative and is usually all that is required. Oil should be given only if the meconium is not thoroughly evacuated, or if there is a rise of temperature during the first few days, in which case a very small dose is sufficient.

* * *

Preventive medicine. Sir George Newman, chief medical officer of the English University of Health, says that most diseases are the effect of causes in large and increasing measure controllable. Good cooking was advocated as a pre-requisite of good digestion. Poor nutrition is not a result of the properties of the food, but a lack of knowledge. Four principal diseases — pulmonary tuberculosis, influenza, poliomyelitis and cerebro-spinal fever — were known to be conveyed by inhalation of the causal microbe. A clean mouth, clear breathing passages, abstinence from spitting, sneezing, coughing, shouting or breathing at other people, would go a long way toward prevention. The prevalence of venereal disease is a strain on our civilization. Enlightened public opinion will ensure sanitary reform, therefore education in sanitary methods and objects is imperative. No laws can be successfully applied which have not public opinion behind them.

* * *

The graduate nurse, except in institutional positions where medical and nursing care with the continuance of salary, is given, is faced with total loss of income and the added expenses of illness or accident. Nurses are proverbially extravagant, and in so many cases live from hand to mouth. To them a plan of a cheap form of accident and sickness insurance should appeal. We must in the future do our utmost to influence the young graduates to protect themselves and their income by some form of insurance.

No two things differ more than "hurry" and "dispatch." Hurry is the mark of a weak mind, dispatch of a strong one. A weak man in an office is like a squirrel in a cage — is laboring eternally, but to no purpose; like a turnstile, he is in everybody's way, but stops nobody; he talks a great deal, but says little; looks into everything, but sees into nothing; has a hundred irons in the fire, but few of them are hot; and with the few that are, he burns his fingers.

— COLTON

* * *

Gratitude is the memory of the heart.

— J. B. MASSIEU

* * *

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A Different Approach to Psychiatric Social Work

CYRIL GREENLAND

Teamwork in the care of the psychiatric patient ensures more effective treatment.

THIS DEPARTMENT was established in October, 1958. Looking back over the work provides an opportunity to consider our aims and what has been achieved. The function of the Social Work Department is to bring to the psychiatric team information about the social factors that underlie the symptoms presented by the patient on admission to hospital. In this way the social worker helps to identify areas of pressure which may have precipitated the illness. Having defined these areas of conflict, the cooperation of the patient and his family is sought in the process of dealing with them. This function has two interlinked aspects which can be considered under the headings of "inner" and "outer" needs. "Inner" needs are dealt with by helping those patients towards a better understanding of the nature of their problems and on this basis to plan realistically for the future. "Outer" needs are satisfied by rendering appropriate services which, by removing obstacles, provide opportunities for development in the direction of independence. In short, social work is concerned with interpreting the social needs of patients and their families and providing or helping to provide services that encourage healthy impulses towards growth and maturity.

Because we are so few in number and because the demand for service is so great, in practice only a small proportion of patients who need help are actually seen by social workers. We hope in time to provide much more adequate service. When faced with conditions of chronic staff shortage a number of solutions are possible. The available resources can either be concentrated on a limited area or diluted and dissipated over a much wider one. Neither solution is satisfactory. The first falls short because the large majority of patients are deprived of services to which they are entitled, and in any case, how is one to decide who needs help most? The second is equally ineffective because, like a sudden shower at a time of drought, too little rain may be worse than none at all. This method of working is also frustrating because the social worker will find little or no satisfaction in service which is so limited in scope.

In consultation with the medical superintendent, it was decided to divide our resources. My colleague and her assistants, were to carry the main burden of casework services while, I was to be left more or less free to develop and extend the therapeutic resources of the hospital. This was not, however, a one-man-band affair. If these efforts have been successful it is only because of the help and loyal support I received from the doctors, nurses, attendants, administrative staff, and not least, from my own colleagues.

Our first joint venture was with the blind group. The aim here was to use community resources, in this case the Canadian National Institute for the Blind, for the benefit of our 24 blind patients, most of whom had been in hospital for many years. This started as a Thursday afternoon social club. The next phase was a demonstration workshop run by staff generously provided by the C.N.I.B. It was planned that if it proved worthwhile after three months, the workshop was to be taken over by the hospital. Here we were most fortunate in securing the part-time services of a graduate nurse who, before losing her sight, was on the hospital staff. She has been ably assisted by an occupational therapist aide and members of the community service club who between them provide a service which is of great benefit to our

Mr. Greenland is Chief Psychiatric Social Worker at the Ontario Hospital, Whitby, Ont. Thanks are due to Dr. D. O. Lynch, Medical Superintendent, for permission to publish this article.

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blind and partially-sighted patients.

A similar venture has been the Senior Citizens Club, meeting on Friday afternoon, which provides a very pleasant social occasion for the elderly men and women. This club is supervised by another occupational therapist aide, and staffed by members of the community service club.

One of the difficulties threatening these developments was the shortage of ward staff to supervise and escort patients to these activities. Here, necessity being the mother of invention, a novel and perhaps even a unique solution suggested itself — the community service club. This is a group of women patients united by the single aim of providing service for patients less fortunate than themselves. This club, with its own elected chairman, secretary and leaders, organizes groups to serve the blind, and visits the female pavilions each afternoon. Our experience suggests that opportunities for service of this kind may well be a therapeutic resource of considerable potential value.

In recent years the condition of patients on chronic wards has been the subject of great concern. Evidence now available suggests that the deterioration associated with psychosis is much more related to the environment in which the patient lives than to the illness itself. In short, it is suggested that it is not the illness that is hopeless but rather our attitude towards it. Project Remotivation, a twelve-week "total push" program on the male pavilion, with sociological and psychometric measurement before and afterwards, was a most successful attempt to test out this hypothesis. Particularly rewarding was the response of patients to the appointment of a ward aide, who brought a much appreciated feminine touch. The consequent improvement in the behavior, appearance and habits of these men, most of whom had been in hospital for an average of 16 years, suggests that further consideration could, with profit, be given to the use of female staff on male wards. Members of the Kiwanis Club of Whitby also played a most important part in the Remotivation Project. A similarly valuable development was the industrial workshop which has enabled the patients to sort 6½ tons of auto parts and earn themselves $390.

A further example of the use of community resources has been the classes in English for foreign-speaking patients, sponsored by the provincial Department of Education. A teacher, working under the egis of the O.T. Department has already achieved most encouraging results. This may well prove to be the beginning of a much more comprehensive hospital educational program.

Developments of this kind are in line with the new mental health program. The aim is not only to provide an expanded and more active service, but also to bring mental hospitals closer to the community. This involves not only imaginative changes in policy and organization but also in the training of staff. A recent addition to the syllabus of the school of nursing is a course of 48 lecture-demonstrations on the sociology of social problems. This will be consolidated by a month of practical work in the social work department.

The community is also enthusiastic to be of service to the mentally ill. In this respect there have been a number of exciting developments. Of particular interest has been the recent inauguration of the Oshawa and Ontario County Branch of the Canadian Association of Mental Health. Equally important is the "Orientation Course in Psychiatry," at this hospital, for public health nurses. It is hoped that this will lead to more effective cooperation between the public health departments and Ontario Hospitals, particularly in the fields of prevention, early diagnosis and aftercare.

The past ten years have seen great advances in the treatment of mental illness. Looking forward to the next decade one can already see the outlines of new and possibly very different patterns of psychiatric service. It now seems likely the greatest progress will be made in fields of pharmacotherapy and social psychiatry. The success of both these developments will depend on the closest collaboration between psychiatry, nursing and social work.

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MARGUERITE D'YOUVILLE CLUB

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IN THE FALL OF 1956, UNDER the guidance of the late Sister Levasseur, then director of education, a new club was formed at the Grey Nuns' school of nursing in Regina. Sister Levasseur felt that there was a need to provide recognition for honor students and at the same time a means by which these same people might give scholastic assistance to other students. The Marguerite d'Youville Club, named after the foundress of the Grey Nuns' nursing order in Canada, adopted the motto "Science through Friendship."

A meeting was held and the constitution was drawn up. In order to be eligible for membership, students must first obtain an average of 85 per cent after completion of the six months' preliminary period. They must also have shown excellent decorum in the hospital and the school of nursing. These students are presented with a membership card signed by the director of nurses, at their capping ceremony, signifying their eligibility for membership. Membership in the club is on a voluntary basis. The student signs an agreement to show that she is willing to join the club and to abide by the regulations.

Membership pins are presented by the alumnae association which has assumed financial responsibility for the club. To receive a pin, the student must instruct another student whose name has been submitted to the club by the faculty. A record of subject matter covered is kept and the number of hours of tutoring. The round pins are one-quarter inch in diameter and consist of a centre of gold depicting a lamp, the symbol of nursing, upon an open book, the symbol of knowledge, encircled by a blue border with "Marguerite d'Youville Club" in gold lettering. Pins may be worn on the upper left side of the student uniform.

Membership to the club is forfeited:

1. Voluntarily,
2. By inability to maintain membership standards,
3. By withdrawal from the school of nursing.

Club members must maintain an average of over 80 per cent in all subjects. If a student fails to maintain this average in her junior or intermediate terms, she must forfeit her pin. She may regain it by obtaining an average of 80 per cent in the senior term. In the event that the student does not meet the standard in her third and final year, she may keep her pin if the average of all her marks is above 80 per cent. Recognition is given to these students by having their names put on the Honor Scroll in the classrooms. A full page of the yearbook is set aside for a group picture.

The faculty act as advisers to the club. A chairman and a secretary are appointed from members of the faculty. The duties of the faculty advisory committee include presiding at all joint meetings of the Marguerite d'Youville club and the faculty; keeping a record of the proceedings of meetings and the membership of the club; submitting financial matters to the alumnae association; preparing a report for the alumnae association twice annually which includes the names of new members and current members, the number of students tutored and the number of hours spent doing it.

The executive committee of the club consists of a president, vice-president and secretary elected by the members. Members attend joint meetings of the faculty advisory committee and the Marguerite d'Youville Club which are held at least three times a year at the request of the educational director or the president of the club. The meetings take place prior to the announcement of memberships and the distribution of pins. Extra activities of the club include such things as "nursing study nights," when nursing care studies are presented to the student body. These are chosen from the total number written by the students. Club members also help prepare review classes.

What is the value of such a club? To the non-members it serves as an incentive for more diligent study and intellectual activity. To the members it means that they must be exemplars of the standards of the school of nursing and the hospital. It also means that they may assist in ward supervision of preliminary students upon the recommendation of the faculty and clinical instructors. It gives them an opportunity to give of their knowledge and encourages them to think of postgraduate study.

Sciencia per amicitiam — Science through friendship — and hard work.

Miss Dion, a former member of the Marguerite d'Youville Club of Regina Grey Nuns' Hospital, graduated in 1959. She is presently on the staff of the hospital.

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PARENTS AND MENTORS

Schools of nursing are beginning to admit not only prospective students but also their parents — with benefit to both sides.

The day that Betty formally enters the school of nursing, Mother and Dad usually accompany her to the nurses' residence where they may meet her instructors, her director of nursing, her classmates. Then they leave her to the rather mysterious process of becoming a nurse.

In the next three years they will gather scraps of information as Betty writes her weekly letter or comes home on days off and holidays. They will be impressed by her knowledge of cardiac surgery, vaguely worried over what appears to be a crushing schedule of work in the operating room and, sometimes, genuinely distressed when Betty is discouraged and discontented. They would like to help her but they do not know what to do or say since they feel that she is in a world of which they have little or no understanding.

The idea that parents should be brought into the life of the school of nursing is beginning to gain acceptance. In 1957 the Hotel Dieu Hospital, Kingston initiated its Parent Teacher Association. The teaching staff felt that the help of the parents would be invaluable in solving some of the problems that arose in dealing with the students. Last spring, the Montreal General Hospital organized its School of Nursing Associates — a group composed of the parents or guardians of the students. The initial response to the suggestion that such an association might be formed was most enthusiastic. The parents were grateful for an opportunity to learn more about the school and its program.

The executive of the Associates is elected from the ranks of the parents and meetings of the membership take place at its request with an annual meeting definitely scheduled for April of each year. The aim of the Associates is to be as well-informed as possible about the school of nursing, its program and its objectives so that they, in turn, may inform the general public. This could result in a stimulus to recruitment from which the School will benefit. In addition the School will have an opportunity to sample public opinion reliably. A long range objective of the Associates is the provision of bursaries for deserving students as tangible evidence of their appreciation for the training their own daughters are presently receiving.

The concept of the hospital as an integral part of community life is receiving increasing emphasis. It is quite reasonable then to expect that the people within the community should have or be encouraged to take an active interest in those phases of hospital life where they can serve effectively.

In addition to the Associates, the M.G.H. school of nursing has set up a "mentor system" that is unique, according to present knowledge. The members of the student body have come from widely separated areas in Canada and a number of countries beyond our national boundary lines. They also represent varying degrees of maturity and as many differing personalities as there are individuals. The students need help in developing good work relationships and personal relationships. Some require assistance in forming friendships; others need a sympathetic listener and wise counsellor for personal problems. The mentors, who are head nurses, supervisors or administrators, provide the answer. Beginning in September, 1959 each mentor was assigned four girls from the class of students who were just beginning their training. The mentor arranged for interviews with her students during which the members of the little group came to know each other on a more personal basis. During these early months, interviews were frequent but they will diminish in number as the student attains greater seniority. Each mentor is responsible for her particular group of students throughout the entire course of their training. She is the one to whom they will be able to turn for support, encouragement, comradeship, kindliness.

Although still in its infancy, the "mentor system" has proven most gratifying. The mentors enjoy their contacts with the students. This particular class of students has responded by unusually rapid and good adjustment to the life of the school. It is anticipated that a certain percentage of "drop-outs" may be prevented through finding and solving problems in the early stages. The end result is envisioned as a group of nurses who are better developed personally as well as professionally.

The concept of the school of nursing as an educational unit, quite apart from the service needs of the hospital, is an accepted ideal. This has led to a greater appreciation of the needs of the student nurse as an individual and developing personality. The mentor system is a definite step toward meeting normal human needs. J. E. M.



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In Memoriam

Madeline (Spencer) Burnham, a graduate of the Victoria Public Hospital, Fredericton, N.B., died on January 19, 1960 in Stoughton, Mass.

* * *

Mary Norine (Mulcahy) Campbell who graduated from St. Michael's Hospital, Toronto in 1937 died on April 25, 1960.

* * *

Barbara Clark, a graduate of the Children's Memorial Hospital, Montreal in 1934, died on May 6, 1960. She had served as a nursing sister during World War II and had been a staff member of Queen Mary Veterans' Hospital, Montreal, up to the time of her final illness.

* * *

Eglantine Clément, the first nurse to graduate from Ste Justine's Hospital, Montreal died in March, 1960. After graduation in 1910, she served with the Victorian Order of Nurses in the city for several years. Later she returned to her hospital to conduct an orientation program for volunteer workers. She was 84 years of age.

* * *

Effie M. Comper who graduated from Riverdale Isolation Hospital, Toronto in 1929, died on May 1, 1960. She had been engaged in institutional nursing during her professional career, having served on the staff of her hospital for 31 years.

* * *

Eva G. (Ham) Hanna, a graduate of the General Hospital, Stratford, Ont. in 1928, died on March 13, 1960.

* * *

Margaret Emerald (O'Connor) Kitchen who graduated from St. Andrew's Hospital, Midland, Ont. in 1936 died on January 3, 1960.

* * *

Teresa Mary (O'Meara) Lane who graduated from the General Hospital, Ottawa in 1932 died early this year. During her professional career she had engaged in private nursing.

* * *

Elizabeth C. (DuVall) Newlands, a graduate from the New York Hospital, New York in 1922 died in Toronto during 1959.

* * *

Grace Agnes (Hall) Noble who graduated from St. Joseph's Hospital, Port Arthur, Ont. in 1913 died on March 21, 1960.

* * *

Evelyn S. Padgham, a graduate of the Ontario Hospital, London in 1930 died on February 3, 1960. She had been engaged in institutional nursing.

* * *

Florence Edna Payne who graduated from Grace Hospital, Toronto in 1918 died on May 14, 1960.

* * *

Marion Viola Phillips, a 1930 graduate of the General Hospital, Hamilton, Ont., died earlier this year. She had been engaged in institutional nursing.

* * *

Zena Pue, a graduate of the General Hospital, Belleville, Ont. in 1919, died in April, 1960. For the past 30 years she had been on the staff of the Deaconess Hospital, Detroit, Michigan.

* * *

Gladys (Barker) Richards who graduated from Grace Hospital, Windsor in 1932 died on February 3, 1960.

* * *

Madeleine M. Smith, a graduate of the General Hospital, Brantford, Ont. in 1927 died on April 14, 1960. She had engaged in private nursing during her professional career.

* * *

Sarah Woodcock, a graduate of St. Joseph's Hospital, London, Ont. in 1920 died recently. She had been engaged in private nursing.

Board Members

Booker T. Washington once said:

"A board is something long and hard and narrow."

Boards are not made of living wood;
No young sprigs on a board are fitting
Sap makes things grow, you know, and could
Disturb a Board's perpetual sitting . . .
Creative youth makes change and motion
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It sits on youth, without a notion
That youth instead should sit on it.

Frederic Almy — "On the Use of Boards"
Survey, Dec. 1/33 — p. 265.



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Book Reviews

Sociology and Social Problems in Nursing by Sister Mary Isidore Lennon, R.S.M., R.N., B.S., M.A., M.S.S.W. 491 pages. The C. V. Mosby Company, St. Louis, Mo. 3rd ed. 1959. $5.00.

Reviewed by Miss Jean Grose, Educational Director, Misericordia Hospital, Winnipeg, Man.

The purpose of this edition is to present fundamental principles in sociology and to encourage the student nurse to apply them in the care of all patients.

This text is excellent as a sociology reference. Sister Lennon has clearly shown an appreciation of the changing trends in nursing as an integral part of society, and in society as a whole.

The material is presented in orderly sequence. The interest of the reader is held and the context can be readily understood by student nurses.

I was particularly pleased with the chapter on "Communications in the Hospital." This is an important area of nursing on which more emphasis should be laid. I enjoyed the review questions at the end of each chapter both as an aid in teaching and as an incentive to learning.

The Practical Nurse by Kathryn Osmond Brownell, R.N., B.S. and Vivian M. Culver, R.N., B.Ed., M.Ed. 899 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 5th ed. 1959. Price $6.00.

Reviewed by Mrs. B. Gilmore, Coordinator, Misericordia Hospital, Winnipeg.

This book presents a comprehensive and up-to-date outline of the subject matter in a course for practical nurses. A new and completely rewritten edition, it is well abreast of the latest thinking in nursing practice.

The text is divided into 14 units covering the fundamentals of all aspects of nursing care. The presentation is concise and readily understandable. The summary at the end of each chapter provides an excellent review.

The text is highly recommended as a source of information and review for practical nurse students and graduates and as a guide for instructors. Several sections might well serve as a syllabus for courses for the student professional nurse. This is a valuable and welcome addition to the literature available for both practical or professional nurses.



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ALBERTA

Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital, centrally located between two very good summer resorts etc. Salary schedule according to suggested A.A.R.N. namely $275 - $300 & adjusted according to experience since graduation. Living in accommodation available at $30 per mo. & Blue Cross on a 50-50 basis. Apply: Mrs. J. Bergquist R.N., Matron, Municipal Hospital # 43, Bentley, Alberta.

Registered Nurses for 44-bed hospital, salary $325 per mo. with $5.00 increments per mo. after each 6-mo. service, board & room $30 per mo., group medical & hospitalization plans available. Apply: Holy Cross Hospital, P.O. Box 339, Spirit River, Alberta.

Registered General Duty Nurses (4) for 32-bed hospital with program of building an addition this spring. Salary $300 - $330; 21-days vacation with pay after 1 year service plus 11 statutory holidays, 1½ days sick leave accumulative. $30 per mo. deduction for room, board & laundry. $10 extra for 11-7 shift. For further information, apply to: Mrs. Pauline Landry, Matron, Municipal Hospital, Fairview, Alberta.

Registered General Duty Nurses (2) immediately for active 30-bed hospital. Salary $270-$295 per mo., 40-hr. wk., 21 days vacation after 1 year, plus all statutory holidays, 1½-days sick leave per mo., room, board & laundry $30 per mo. if desired. For further information apply: Matron, Municipal Hospital, Magrath, Alberta.

Registered General Duty Nurses for busy 45-bed hospital, with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr. wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

General Duty Nurses (in early fall) for 52-bed active hospital situated on main highway between Edmonton & Calgary. 5 practicing doctors. Salary range $270 - $310 depending on years of experience, less $35 for full maintenance. 3-wk. vacation plus 10 statutory holidays after 1 year service. Pension plan available. Apply to: Mrs. E. Harvie, Matron, Municipal Hospital, Lacombe, Alberta.

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General Duty Nurses for 34-bed hospital. Salary $270 with 6- $5.00 increments every 6-mo. to maximum of $300, modern residence — $20 per mo., 40-hr. wk., vacation 1-mo. including statutory holidays, M.S.I. & Blue Cross plans in force. C.N.A. pension plan available. Apply: Miss M. M. Sissons, Matron, Municipal Hospital, Vulcan, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

BRITISH COLUMBIA

Head Nurse for Pediatric Ward General Hospital with school of nursing. Able to assist with student teaching program. Salary based on experience and/or postgraduate preparation. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

General Duty Nurses (2) (immediately). Starting salary $285, personnel policies in accordance with R.N.A.B.C. recommendations. C.U. & C. Health Plan in operation. Room & board in comfortable nurses' residence $40. Situated on the Pacific Coast near several bathing beaches. Apply: Tofino General Hospital, Tofino, V.I., British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric, Operating Room & General Duty Nurses (Immediately) for new modern 125-bed hospital in central B.C., surrounded by magnificent scenery & excellent sporting opportunities. Starting salary B.C.R.N. $285 plus $14 increment with 2-yr. experience. Modern nurses' residence available. Apply: Nursing Supervisor, Regional Hospital, Prince George, British Columbia.

Operating Room Nurse with postgraduate course for active operating room in General Hospital with School of Nursing. Salary $285 plus increment for experience. Must be eligible for B.C. registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Male Operating Room Nurses (Registered in British Columbia) ability to carry responsibilities of a circulating nurse essential. Experience preferred. Salary $285-$342; differential for postgraduate work. 40-hr. wk., rotating shifts, no "call" work; 4-wk. annual vacation, cumulative sick time, health plan. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Day Supervisor for new 100-bed south eastern B.C. Hospital. R.N.A. contract personnel policies. Staff residence. Apply: Director of Nursing, K.L.G. Hospital, Nelson, British Columbia.

MANITOBA

Registered Nurse (1-Immediately) for 11-bed hospital. Salary $310 per mo. with increments, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit, Birch River, Manitoba.

U.S.A.

Registered Nurses for General Duty, obstetrics, operating room & emergency. Beginning salary: $330 per mo. $10 differential paid for afternoon & night shifts, also for obstetrics, nursery & operating room. 40-hr. wk. Liberal vacation policy, sick leave, holidays. Paid health & life insurance. Please write: Mrs. Doretha Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses (2) for small modern hospital situated in the Whiteshell district of Manitoba. Excellent bus & train services to Winnipeg & Kenora. **One (1) Registered Nurse preferably with O.R. experience.** Starting salary $295 with semi-annual increases of $5.00, 1-mo. vacation after 1-yr., 8-statutory holidays. Apply: Matron, District Hospital, Whitemouth, Manitoba.

NOVA SCOTIA

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses (Immediately). Good personnel policies. Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing Service for modern 100-bed hospital, day duty only, salary open, excellent personnel policies. Interview will be arranged. Forward enquiries to: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

Supervisor of Nursing for modern 42-bed hospital. Residence accommodation available. State experience & salary requested. Direct enquiries to: The Administrator, General Hospital, P.O. Box 909, Sioux Lookout, Ontario.

Supervisor & Public Health Nurses for general program. Supervisor's salary ceiling at present $5,300 per annum & Staff Nursing salary ceiling at present $4,300 per annum. Initial salary dependent on experience. Usual fringe benefits, vacation & sick leave, car allowance etc. Apply: Dr. J. R. Mayers, Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Clinical (Teaching) Supervisor for Operating Room; postgraduate study essential; previous teaching experience desirable; duties to include staff orientation & in-service education; an interesting position for a progressive person; attractive personnel policies; salary in accordance with preparation & experience. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Medical-surgical Clinical Teacher (1). Apply: Director of Nursing, Hotel Dieu Hospital, Kingston, Ontario.

Assistant Superintendent, Registered Nurse for 73-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Instructor for Certified Nursing Assistant Course. Training program is 10-months. 100-bed modern hospital. **Dietitian** for 100-bed modern hospital. Excellent personnel policies & salary scale, pension plan. **Physiotherapist** for 100-bed modern hospital. Duties to commence September 1, 1960. Apply to: Sister Superior, St. Vincent de Paul Hospital, Brockville, Ontario.

Instructors for Medical-Surgical Nursing, & Nursing Arts, in school of nursing, with new facilities opened this year. Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Head Nurse for Newborn Nursery in modern department; postgraduate experience desirable, but previous experience would be considered. Attractive personnel policies. Salary in accordance with qualifications. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England

Registered Nurse to take charge of new operating room — also **General Duty Nurses** for modern 55-bed hospital, situated in Bruce County, town of 3,000 people, on the shores of Lake Huron. Accommodation available in nurses' residence. Excellent recreational facilities, & all churches represented. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

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(2) Directors of Nursing in Hospitals: up to $5,400 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $4,050 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

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(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for well equipped 60-bed hospital in small, friendly community on main line of C.P.R. Liberal personnel policies with salaries above R.N.A.O. recommendations. Attractive living accommodations available. Apply: Director of Nursing, Lady Minto Hospital, Chapleau, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Duties to commence in July, 1960. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

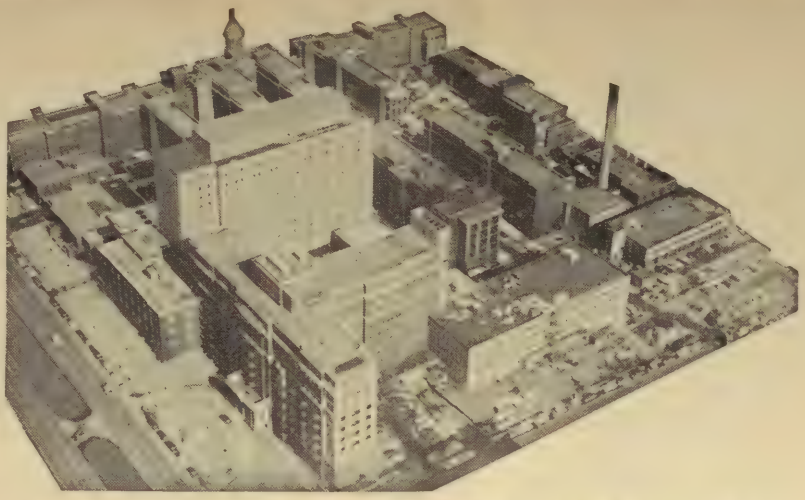
Registered General Duty Nurses (all departments) in new 300-bed hospital in Niagara Peninsula. Starting salary $270 with 3-annual increments to $300 per mo., 40-hr. 5-day wk., with 3-wk. annual vacation, residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Staff Nurses for all departments (including Operating Room); 5-day wk.; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 73-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305 for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.



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General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurses qualified for generalized program. Minimum salary $3,500 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, **Fort William & District Health Unit,** 900 Arthur Street, Fort William, Ontario.

Public Health Nurse for generalized program. Minimum salary $3,400, allowance for experience, cumulative sick leave, shared pension, P.S.I. & hospitalization, 5-day wk., 3-wk. vacation, car allowance or staff car, increment $150. Apply to: Dr. G. Q. Sutherland, M.O.H. City Hall, Guelph, Ontario.

Public Health Nurse for generalized program. Salary $3,500 - $4,375 over a 5 year period, pension plan, P.S.I. Apply: Mr. D. T. McLeod, Secretary-Treasurer, District of Kenora Health Unit, Box 174, Kenora, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurses Qualified, generalized program, salary range $3,500 - $5,000, good personnel policies. Apply to: The Director, Ontario County Health Unit, Pickering, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, hospital plan, hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½-days monthly, vacation 4-wks. a year, allowance for use of own car. Salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J .R. Mayers, M.O.H & Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Public Health Nurses for Staff positions. Starting salary $3,600 with uniform allowance & annual increments. Good personnel policies. Apply to: Miss Helen Saunders, Director, Victorian Order of Nurses, Windsor, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

P.E.I.

General Duty Staff Nurses for 12-bed hospital, 8-hr. shifts, 44-hr.-wk., room & board provided. Apply to: Superintendent, Stewart Memorial Health Centre, Tyne Valley, Prince Edward Island.

BERMUDA

Assistant Matron with postgraduate, or experience in administration nursing service, for 140-bed hospital with building program in operation. For further information apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

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Registered Nurses willing to serve as volunteer Home Nursing Instructors will be welcomed by the Red Cross Branch in your community.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Matron (preferably bilingual) for July for newly constructed modern 23-bed General Hospital located at Murdochville. Duties to include supervision of personnel & general hospital maintenance. Excellent recreation facilities including indoor swimming & artificial ice. Three (3) churches. Reply stating age, experience & training to Box No. L, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Science Instructor for modern 150-bed hospital school 60-70 students. A.N.P.Q. salary scale in operation. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Laboratory Technician for new modern 24-bed hospital located in centre of Gaspe Peninsula, excellent recreation facilities including indoor swimming & artificial ice. Salary commensurate with qualifications. Reply stating training & experience to: Box L, The Canadian Nurse Journal, 1522 Sherbrooke Street west, Montreal 25, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurse for new modern 24-bed hospital located in centre of Gaspe Peninsula to be opened in August. Working conditions in accordance with Quebec Association of Nurses standards. 44-hr. wk., excellent recreation facilities including indoor swimming & artificial ice. Reply stating training & experience to Box L, the Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

SASKATCHEWAN

Matron — Superintendent Female (Permanent position, duties to commence as soon as possible) for modern 26-bed hospital in northern Saskatchewan. Starting salary $400 per mo. less $30 per mo. for room & board in a separate residence. 1-mo. annual vacation. Air transportation from Prince Albert or Edmonton & return, once a year, paid by the employer. Apply giving full details of qualifications (age, education, experience & references, etc.) to the: Manager, Municipal Corporation, Uranium City, Saskatchewan.

Matron (1); Registered Nurses for General Duty (2) for 8-bed hospital at Hodgeville, Sask. Duties to commence immediately. Salary & all benefits according to SRNA. Maintenance available at $30 per mo. Contact: Mrs. M. Rumpel, Secretary, Union Hospital, Hodgeville, Saskatchewan.

Matron & Graduate Nurse (1) highest salary paid, 1-mo. vacation with pay after years service, sick benefits, maintenance supplied. If interested apply to: A. J. Hammel, Secretary, Union Hospital, Prelate, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Graduate Nurse (1) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 40-hr. work wk., 3-wk. vacation, plus statutory holidays. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi. from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

DIRECTOR OF NURSING

REQUIRED FOR

160-bed General Hospital

Please reply giving full particulars, including salary expected, to the:

Administrator
KIRKLAND AND DISTRICT HOSPITAL,
KIRKLAND LAKE,
ONTARIO

JEAN TALON HOSPITAL

MONTREAL

REGISTERED NURSES

WANTED

Excellent working conditions: pension plan, salary range $57 - $80 per week according to qualifications. Statutory holidays, paid sick leave, paid vacation, life insurance, sickness insurance. Free: 1 meal daily, laundering of uniforms.

For further information write to:

LA DIRECTRICE DU NURSING
HOPITAL JEAN-TALON
1385 EST, RUE JEAN-TALON
MONTREAL 35

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

OPERATING ROOM TECHNICIANS

THE MONTREAL GENERAL HOSPITAL

would welcome applications for operating room technicians

Please apply to:

THE DIRECTOR OF NURSING,
THE MONTREAL GENERAL HOSPITAL,
1650 CEDAR AVE.,
MONTREAL, QUEBEC.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for Operating Room, Delivery, Nursery — all shifts. Starting salary $340 per mo., liberal shift differential, 9 paid holidays, insurance, sick leave & vacation. Contact: Director of Nurses, Washington Township Hospital, 2000 Mowry Avenue, Fremont, California.

General Duty Nurses for large teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Operating Room Nurses: Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (½) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Monthly salary rates: $370-$400 days; & $400-$430 afternoon & nights, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $450 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurse — Immediate positions available in medical-surgical, obstetrical, pediatrics & operating room units of modern, non-profit, J.C.A.H. accredited 125-bed General Hospital located in beautiful suburban area just 20-min. from downtown Detroit. Progressive, expanding organization with liberal personnel policies & in-service education program. Salary commensurate with experience with differential for afternoon & evening shifts. Apply: Director of Nursing, The Lynn Hospital, Lincoln Park, Michigan.

School Nurse for small infirmary in girls' private school, 20-mi. from New York City., pleasant opportunity. Apply: P.O. Box 308, Summit, New Jersey.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80) bi-weekly until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

OPERATING ROOM STAFF

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Staff Nurses for 200-bed General Hospital; heart of Los Angeles cultural & educational center. **General Duty:** $335 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays 12 day sick leave. Cotton uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever feasible. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South, St. Louis Street, Los Angeles 23, California.

ALBERTA

Public Health Nurses (2) Those with Public Health qualifications given preference but R.N. considered. Starting salary according to experience & qualifications. Minimum, with P.H. (N) Certificate $3,300; without P.H. (N) Certificate $3,000; annual increments $120, free transport, uniform allowances. For further particulars apply to: Medical Officer of Health, Health Unit, Athabasca, Alberta.

Director of Nursing (Duties to commence as soon as possible) for modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan & direct education & service programs. Perquisites include suite with service, pension plan, 4-wk. vacation, sick benefits. Salary: $7,000 - $9,000 annually depending on qualifications & experience. Address replies to Chairman, Calgary Hospitals Board, General Hospital, Calgary, Alberta.

Associate Director of Nursing (Duties to commence as soon as possible) for modern 750-bed accredited civic General Hospital (200-bed addition being built). Salary range: $5,000 - $6,500 per yr. depending on qualifications & experience. Liberal benefits & personnel policies. Address replies to: Administrator, General Hospital, Calgary, Alberta.

MANITOBA

Registered Nurse (Immediately) for 10-bed hospital in northern mining town. Starting salary $300 per mo., with semi-annual increments. Full maintenance & laundry $40 per mo., 4 nurses on staff, fare paid after 6-mo. employment. Health plan available, 21-days vacation annually with pay. Apply with particulars to: Dr. A. Marrack, Snow Lake, Manitoba.

ONTARIO

Public Health Nurse for generalized program with the Bruce County Health Unit. Pension, surgical-medical, group insurance & cumulative sick leave plans available, 4-wk. vacation, car provided if required. Apply to: T. H. Alton, Secretary-Treasurer, Bruce County Health Unit, P.O. Box 70, Walkerton, Ontario.

Registered Nurses & Certified Nursing Assistants needed to open new 165-bed wing in a 365-bed General Hospital located in suburban Toronto. Good salary, personnel policies include 5-day work wk., 8 statutory holidays. R.N. vacation after 1-yr. - 3-wks. Cert. N.A. - 2-wks. Living-in accommodation. Apply to: Director of Nursing, General Hospital, Scarborough, Ontario.

Registered Laboratory Technician for new 58-bed hospital with new equipment in laboratory. Apply to: The Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Graduate Nurses, Certified Nursing Assistants for General Duty for new 58-bed hospital. For information please write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

ALBERTA

General Duty Nurses (2) Salary $270 - $300 per mo. plus other benefits, 40-hr. wk., train fare from any point in Canada will be refunded if employed for 1-year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta. Phone 335.

BRITISH COLUMBIA

Clinical Instructor (Medicine) for school of nursing in interior of British Columbia. Postgraduate preparation required, experience preferable. B.C. registration required. Salary based on preparation and/or experience. Position available **September 1st., 1960.** Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Nurses with postgraduate and/or experience. for 600-bed hospital, salary based on experience and qualifications. Apply to: Director of Nursing, St. Paul's Hospital, Vancouver, British Columbia.

ONTARIO

Instructors (Science & Psychiatry) also Head Nurse for delivery room & General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

2 INSTRUCTORS

Certificate in Nursing Education required - One to teach basic Science - Student enrollment 70-80 - One class per year, registers in September - Well equipped modern School & Residence

ASSISTANT DIRECTOR NURSING SERVICE - EVENING OR NIGHT PERIOD

Previous supervisory experience required. Certificate in Nursing Service Administration desirable.

200-bed hospital - fully accredited. Pleasant city 38,000 close to larger centres. Good salary & personnel policies. Additional salary for advanced preparation above positions. *For further details apply to:*

THE DIRECTOR OF NURSING, GENERAL HOSPITAL, GUELPH, ONTARIO

CLASSROOM & CLINICAL INSTRUCTORS
GENERAL STAFF NURSES

required

The General Hospital of Port Arthur

Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1 yr. in service.

WRITE:

DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

INSTRUCTOR

REQUIRED

SCHOOL OF NURSING

Are you a Registered Nurse Instructor with a few years' experience?
Would you like the opportunity of trying your own ideas in a smaller situation?

If so, apply to:

THE DIRECTOR OF NURSING,
VICTORIA HOSPITAL,
RENFREW, ONTARIO.

Good personnel policies.
Salary open to negotiation.

GENERAL DUTY NURSES

WANTED

Salary — $265 - $315 per month 40-hour week, no split shifts

Vacation — 3 weeks after one year, statutory holidays — eight (8) sick leave — cumulative from date of employment

Transportation — advanced on repayable basis for 75-bed fully accredited hospital built in 1956, located in south-western Ontario.

Apply to: Director of Nursing,

SYDENHAM DISTRICT HOSPITAL
WALLACEBURG, ONTARIO

BRITISH COLUMBIA

General Duty Nurses Salary $285 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurses (2) for 21-bed United Church Mission Hospital. For Information regarding salary & personnel policies, kindly write to: The Matron, Queen Charlotte Islands General Hospital, Queen Charlotte City, British Columbia.

MANITOBA

Registered Nurses for Swan River Valley Hospital. Salary $280 with 4 semi-annual increments to $300, 40-hr. wk., 3, 8-hr. rotating shifts, 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Recreational facilities include golfing, fishing, swimming, curling, etc. Apply to: Swan River Valley Hospital, Swan River, Manitoba.

NOVA SCOTIA

Graduate General Duty Nurses (2) Operating Room Nurse (1) for small hospital in beautiful Annapolis Valley. For further information, please contact: Superintendent, Annapolis General Hospital, Annapolis Royal, Nova Scotia.

SASKATCHEWAN

Matron: General Duty Nurse (1) immediately for 9-bed hospital. Salary $315 & $290 respectively, increments, 40-hr. wk., 12-days sick leave, 3-wk. vacation after 1-year service, uniforms laundered, room $10 & meals 25¢. Apply to: D. J. Wiley, Secretary-Treasurer, Saltscoats & District War Memorial Hospital, Saltcoats, Saskatchewan.

ALBERTA

Nurses for General Duty (2) in 29-bed hospital near summer resort. Salary $270 per mo. Excellent residence. Apply: Matron, Municipal Hospital, Eckville, Alberta.

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. **Nurses Aides** — with vocational training. Salary $177-$201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

Public Health Nurses — opening for bilingual nurse (1) salary range $3,630 - $4,158, liberal benefits. Apply to: Peace River Health Unit No. 21, Peace River, Alberta.

BRITISH COLUMBIA

Registered Nurses for General Duty Nursing (2) in 18-bed hospital located at Nakusp, B.C. Accommodation provided in the hospital. Apply to: The Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Registered Nurse for 30-bed hospital, starting salary $285 per mo., rotating shifts with 40-hr. wk., 11 statutory holidays & 1-mo. vacation with pay after 1-yr. service. Pleasant nurses' residence next door to hospital, room and board $40. Address replies to: The Matron, Community Hospital, Grand Forks, British Columbia.

Head Nurse for Medical Ward in General Hospital with school of nursing, located in the interior of B.C. Salary based on experience and/or postgraduate preparation. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Registered Nurses (September) for modern active 25-bed hospital on beautiful Lake Windermere in the Canadian Rockies. Excellent recreational facilities all yr. 90-mi. from Banff & Lake Louise. Policies according to RNABC. Basic salary: $285 per mo. Excellent residence accommodation with full maintenance: $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

ONTARIO

Operating Room Supervisor (fully qualified & experienced) Good salary, 5-day wk., other benefits. Apply to: Mr. F. P. Chaffy, Administrator, The Cottage Hospital, Pembroke, Ontario.

Public Health Nurse (qualified) generalized program, salary $3,400, annual increment $200, 5-day wk., car allowance ten cents per mile, group insurance plan, 4-wk. vacation. Apply to: Dr. W. N. Turpel, M.O.H. & Director, Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurses. Applications are solicited for Simcoe County Health Unit. Personnel policy on request. Write to: Secretary-Treasurer, Court House, Barrie, Ontario.

U.S.A.

Operating Room Supervisor for 230-bed General Acute Hospital, JCA; faculty status with fully accredited NLN school, 50-students. B.S. desired and/or postgraduate study required. Liberal policies, 40-hr. wk. Salary to $6,000 pending professional background. Growing attractive community lake area. 65-mi. NYC. Write: Assistant Administrator, Danbury Hospital, Danbury, Connecticut.

UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

TOWNSHIP OF NORTH YORK

(METROPOLITAN TORONTO AREA)

requires

PUBLIC HEALTH NURSES

Permanent appointments. 5 day, 35 hour week. Excellent employee benefits. Car Allowance. Duties to commence August or September 1st. Population of Municipality 240,000.

Salary range: $73.86 - $77.16 - $80.47 - $84.87. (Allowance granted for experience).

Applications or enquiries may be addressed to:

DR. C. E. HILL, MEDICAL OFFICER OF HEALTH, TOWNSHIP OF NORTH YORK,
5000 YONGE STREET, WILLOWDALE, ONTARIO.

GLACE BAY GENERAL HOSPITAL

GLACE BAY, NOVA SCOTIA

has openings for

2 Clinical Supervisors — 2 Medical-Surgical Supervisors —

1 Nursing Arts Instructor —

40 hour week

3 weeks vacation and 8 statutory holidays

Apply: Administrator,

GLACE BAY GENERAL HOSPITAL, GLACE BAY, NOVA SCOTIA.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education

Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

THE SCHOOL OF NURSING, BROCKVILLE GENERAL HOSPITAL

BROCKVILLE, ONTARIO

Requires

Surgical Nursing Instructor

Requirements: University preparation in Nursing Education

Salary differential for degree

Progressive Policies in Progressive Surroundings.

HEAD NURSES

(2) with Obs. experience, for 45-bed hospital, 12-bassinets. Starting salary $335, 40-hour week, 7 paid holidays. Shifts open: 3-11; 11-7. Send resume including experience & date available to:

SISTER MARY JACQUETTA, DIRECTOR, SAINT ELIZABETH HOSPITAL, RED BLUFF, CALIFORNIA.



Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour* week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

KINGSTON GENERAL HOSPITAL

requires

Assistant evening Supervisor (1)
Operating Room Head Nurse

for:

Neurosurgery, Ophthalmology, Ear, Nose and Throat surgery.

General Duty

for:

O.R., Medical, Surgical Floors and Intensive Care Unit
(male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants
Trained psychiatric attendants (F)

For full details relating to hours, vacations and benefits, apply to:

DIRECTOR OF NURSING, KINGSTON GENERAL HOSPITAL, KINGSTON, ONTARIO

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

PUBLIC HEALTH NURSE

REQUIRED FOR

a rural urban district in a northwestern Ontario Health Unit. Nurse will live in a city of 45,000 population. Hospital plan, P.S.I., Pension Plan, sick leave 1½ days monthly, 4 weeks vacation, generous car allowance. Salary commensurate with experience.

Apply to:

DR. W. C. MacPHERSON, DIRECTOR
PORT ARTHUR & DISTRICT HEALTH UNIT
93 BALSAM ST., PORT ARTHUR, ONTARIO

REGISTERED NURSES AS FLOOR SUPERVISORS

In Geriatric Institution near New York City. Starting salary $4,300 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. No deduction for meals, residential accommodations $200 year.

Write:

EXECUTIVE DIRECTOR,
DAUGHTERS OF MIRIAM,
CLIFTON, NEW JERSEY.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available in this medical teaching centre. Vacation relief positions are available with an opportunity to enjoy an excellent summer climate and an attractive social activities program.

B.C. Registration is required with a starting salary of $299 per month for experienced nurses.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

THE OTTAWA CIVIC HOSPITAL

WITH

A capacity of 1200 beds including
A new modern 300 bed unit

OFFERS

An interesting variety of experiences

Good personnel policies

Salary, allowance for experience and postgraduate courses.

Apply:

DIRECTOR OF NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

NURSES

REQUIRED AT

ROSEWAY, HOSPITAL

SHELBURNE, N.S.

Superintendent of Nurses - $4,200 - $4,950
Nursing Supervisor - - - $3,240 - $3,750
Operating Room Nurse - $3,120 - $3,600
Staff Nurses - - - - - $2,880 - $3,360

Full Civil Service benefits.

APPLY TO:

NOVA SCOTIA CIVIL SERVICE COMMISSION
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Address enquiries or requests to:

Advertising Manager, Ruth H. Baumel, The Canadian Nurse Journal

1522 Sherbrooke Street West, Montreal 25, Quebec.

* * *

Editorial Advisors: Alberta, Miss Irene M. Robertson, 11831-87th Ave., Edmonton; **British Columbia,** Miss Marion E. Macdonell, 1807 W. 36th Ave., Vancouver 13; **Manitoba,** Miss Sheila L. Nixon, 25 Langside St., Winnipeg; **New Brunswick,** Miss Shirley Y. Alcoe, 180 Charlotte St., Fredericton; **Newfoundland,** Miss Isabel Sutton, 66a Mullock St., St. John's; **Nova Scotia,** Mrs. Hope Mack, Nova Scotia Sanatorium, Kentville; **Ontario,** Miss Jean Watt, R.N.A.O., 33 Price St., Toronto; **Prince Edward Island,** Sr. M. David, Charlottetown Hospital; **Quebec,** Miss Geneviève Lamarre, Hôpital de l'Enfant Jésus, Quebec City (French), Sr. M. Assumpta, St. Mary's Hospital, Montreal (English); **Saskatchewan,** Miss Victoria Antonini, S.R.N.A., 2206 Retallack St., Regina.

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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
In combination with the
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Between Ourselves

Although there was a remarkably good registration at the recent convention in Halifax, the number who were present was actually only a very small fraction of the total membership of the Canadian Nurses' Association. In order that all of the members may have a share in the interest, and enthusiasm and, above all, become aware of the momentous decisions reached there, your editors have completed their accounts with all possible speed.

The general consensus was that it was an excellent program. There was no sag in the attendance, even on the last day. From the rate that flash bulbs kept popping at every session we would judge that many of your delegates will be illustrating their reports to chapter meetings with colored slides. Unhappily, from the *Journal's* point of view, the profusion of pictures taken did not help us to provide many illustrations for your interest. Despite dozens of enquiries, it seemed that only one photographer, Miss CLARA R. AITKENHEAD of Sherbrooke, Que., had two cameras with her — one for color, the other for black and white pictures. We are most grateful to Miss Aitkenhead for the pictures that enliven the story of the convention.

* * *

The announcement of election results brings a new panel of leaders to the fore. Next month we shall devote Nursing Profiles to the introduction of the 1960-62 members who will head up the CNA Executive Committee. The key member of this group is, of course, the new president, Miss HELEN M. CARPENTER. Well known professionally throughout Canada, our introduction will give you a few glimpses at Helen Carpenter, the woman.

As we checked our listing of the past presidents of the CNA, we found that eight of the twenty have passed away; eight of the presidents were residents of Ontario at the time they took office, with Quebec four, British Columbia three, Saskatchewan two, Alberta and Manitoba one each. Since 1922 when the name "Canadian Nurses' Association" became the official title, five of the presidents have served two terms of two years each. There has not been a president from any of the Maritime provinces though two of the vice-presidents elected this year reside there.

Great interest has been aroused over the new Nightingale School of Nursing that is receiving its first class of students this month. MRS. BLANCHE DUNCANSON describes the pattern of organization and lists the well qualified staff members who will be assisting her in the development of the program.

International interest has been aroused in this venture since its forerunner, the first Nightingale School, that was established in St. Thomas's Hospital, London, England, is this year celebrating its one hundredth anniversary. Special comment on that celebration may be found in *International Nursing Review.*

* * *

Next month we plan to publish the latest revision of the very useful "Clinical Laboratory Procedures" by DR. E. M. WATSON that has appeared twice before in our *Journal.* As previously, reprints of this material will be made available for sale to the students in schools of nursing as well as to any graduates who may wish to procure the separate copies. The price of single copies will be 15 cents with reductions for quantities as follows:

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25 to 100 copies — 10 cents each
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Payment should accompany your order to ensure prompt delivery. Please include 15 cents for exchange if payment is made by cheque. An order form appears on page 844 for your convenience in placing your request ahead of time.

* * *

Speaking of forms, we are immensely pleased that those of you who have moved recently have made such excellent use of the change of address form first published in last May's issue. It is repeated on page 844 and will be included from time to time in the months to come.

* * *

Last June, we anticipated in this column the publication this month of an article on retinal detachment. It has been decided to postpone this material for a few months since it is planned to devote an entire issue to various eye conditions soon.

I think, therefore I am. — DESCARTES



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Administration—Subcutaneously or intramuscularly. Adults: average dose is 1 cc. Repeat q.4h. as needed. Children: dosage varies according to age. Usually 0.5 cc. to 0.8 cc. is sufficient.

In emergencies, may be injected by slow intravenous administration given over a period of seven to ten minutes in a dosage of 0.5 cc.

Manufacturer—Carter, Cummings & Co. Ltd., Aurora, Ont.

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Manufacturer—Schering Corporation Limited, Montreal 9.

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Administration—Instil or spray into nostrils.

Manufacturer—John Wyeth & Brother (Canada) Limited, Walkerville, Ontario.

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Administration—Suggested dosage is normally every 4 to 6 hours: Age 1 to 3 years, ½ teaspoonful, repeated in 2 hours if necessary. Age 3 to 10 years, ½ to 1 teaspoonful, repeated every 30 minutes up to a total of 3 teaspoonfuls. 10 years and over 1 to 2 teaspoonfuls, with repeated doses of 1 teaspoonful.

Manufacturer—Abbott Laboratories Limited, Montreal 9.

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Manufacturer—Ciba Company Limited, Dorval, Quebec.

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Random Comments

Dear Editor:

I want to commend you and thank you for the fine quality of "our" magazine and to add that I appreciate having the magazine in the two separate languages. I admit that I read it more avidly here than I did at home and appreciate the way it keeps me abreast in the various aspects of nursing, including the new drugs. I send my used copies to an Indonesian nurse on another island who is interested in nursing in other countries and also uses the *Journal* as a means to improve her English.

With the delay of surface mail, I received the November issue recently and wish to comment on the "Nurse-Midwife" articles which I think are very good. In my two and a half years on this island I have been called upon to do a lot of midwifery without any real training in that field, my only experience being several years of rural nursing in Saskatchewan. I can even repair episiotomies now without shaking too much! The large percentage of our cases are home deliveries and we have had virtually no postpartum infection even in the smallest, darkest bamboo huts. As in all Eastern countries, child birth is accepted as a very natural thing and hence all deliveries can be handled nicely without anesthetic. We ordered Trilene from home but so far have used it only in other minor things, never yet in obstetrics.

Aside from service in foreign countries, I think there is a real place and definite need for nurse-midwives in Canada when I think of the rural and outpost areas where there are few doctors and these so overworked. And with Miss Mills, I agree that also in the bigger centres they can play an important role.

Anne Warkentin,
Tobelo, Halmahera, Indonesia.

Dear Editor:

In our June 1960 issue in the article "Bed-Pan Hands" I read as follows: "Are any soaps or detergents good for the skin? No!" Why, then, is foam (made from Sunlight and Dial soaps) being applied to open bed-sores? This I know to be a fact.

During my training we were taught not to use soap on bed-sores, but rather to keep the area dry with surgical powder and prevent pressure. I am very anxious to learn where

this soap treatment originated and if you consider it feasible.

The article in the May 1960 issue, "The Treatment of Deep-Seated Ulcers by Exposure to Air and the Use of Oxygen" was most interesting, but nursing homes do not have hospital facilities.

Jane Lewis, Manitoba

¶We would welcome comments on the above questions from the readership. Ed.

Dear Editor:

I have been doing private duty nursing for the past four years and find that you certainly have to keep up with the times in this type of work. We are expected to take over anything from complicated chest surgery to cerebro-vascular accidents without changing stride. To do this, I read as much as I possibly can in various text books, nursing journals, etc.

The "New Products" section in our *Journal* is an excellent source of information, but I have often wished that the drugs could be published in groups, i.e. a page of tranquillizers, sedatives, laxatives, etc. We could then file them for further reference. I once undertook to clip them and paste them in categories but found it too much work and very complicated. If they were classified according to action one would soon accumulate a valuable file for ready reference.

A section for exchange of ideas in coping with various nursing problems would be helpful and interesting.

Gertrude Willson, Alberta

¶We will give some thought to your suggestions. Ed.

Dear Editor:

May I take advantage of this opportunity to congratulate you on the effort put into the production of a French-language journal for nurses of that language. The articles we read are of the best written and the subjects are chosen with art. But, would it be possible to accord a little more important place to the French-speaking nurse? This question is asked without prejudice and is merely a proposal. On the whole, it is also the sentiments of my colleagues.

M. G. Picard, Quebec.

¶It takes time for things to work out. Authors must be allowed to find for themselves the road to publication. One must aim for top quality and this will come with time. We are far from feeling desperate about it! Ed.

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 9

MONTREAL, SEPTEMBER 1960

ATLANTIC CONVENTION

THE 30TH BIENNAL CONVENTION of the Canadian Nurses' Association has come and gone. It was a history-making meeting, as will be seen from this day-to-day account of activities, and in general a very busy, exceedingly pleasant and successful event. With a total registration in excess of eleven hundred, there was a gratifying representation from every province. These delegates will return to their various chapters and districts to report to those who stayed at home to carry on the daily round of work. The task of trying to remember all of the important highlights from five very full days can be rather staggering. Ask any delegate entrusted with the responsibility! To help them and to inform those of you who may not hear a delegate's report we have prepared our detailed summary of this Atlantic convention.

SUNDAY

Convention week began under sunny skies. By 10:00 a.m., nurses were streaming into the Queen Elizabeth High School to register, to pick up convention folders and name tags, to sign up for the various social events and to begin the delightful business of renewing acquaintances and friendships that is so much a part of such meetings. The pretty Nova Scotian tartan was much in evidence. Every name tag had a tiny border of it and each registrant received a memento to remind her of the early history or resources of the province. Members of the Executive Committee wore a purple thistle and bow of tartan on their labels. Other registrants received a novelty tartan boutonnière; some treasured a shell ash tray, some a little golden seahorse. Then, the formalities of registration behind them, the remainder of the day until early evening was free for sightseeing, visiting or just "loafing."

Shortly before 7:00 p.m. nurses began arriving to take part in the religious services planned for them. Those of the Roman Catholic faith gathered at beautiful St. Mary's Cathedral for the evening benediction. Protestants worshipped at the historic Church of St. Paul whose parish records date back to June 21, 1749.

Wearing mortar boards, gowns and hoods, the president-elect, HELEN CARPENTER, and second vice-president, E. A. ELECTA MACLENNAN read the evening lessons. There, in the peace and quiet of these lovely old churches, we had time to reflect again on the origin of our profession; to speculate briefly on what might be ahead; perhaps, to renew again that spirit of service to others which had first led us into nursing.

The services over, some nurses went on to receptions planned by alumnae groups. Many, feeling the combined effects of sun, sea air, excitement and a long journey, found their way back to hotels, motels and tourist homes for a good night's rest as preparation for a busy week.

MONDAY

Morning Session

Halifax sparkled in brillant sunshine as the registrants, the exhibitors, the press, the translators and the technicians poured into the Q.E.H.S. auditorium from chartered buses provided by the city after a plasterers' strike halted the completion of the fine new addition to the Hotel Nova Scotian.

Where else in Canada could be found not one, but two student nurses skilled in the playing of bag-pipes? With the stirring skirl of "The Road to the Isles" the platform party was escorted down the aisles for the opening ceremonies.

To the HON. ROBERT L. STANFIELD, Premier of Nova Scotia, was accorded the privilege of officially opening the convention. In his brief comments, Mr. Stanfield paid high tribute to the members of the nursing profession, noting that though many other professional groups, even politicians, were often severely criticized, even the jokes about nurses were usually flattering.

Other dignitaries and visitors added to the welcome that was so warmly extended. Miss MARGARET MATHESON, president of the Registered Nurses' Association of Nova Scotia had a special word of greeting for the groups of student nurses from every province. Miss ALICE SHER, a member of the professional staff of the International Council of Nurses, noted that the CNA was the third largest national association in the ICN and was looked to for leadership by the smaller member countries.

As she took the roll call by provincial associations, Miss M. PEARL STIVER observed that the voting body of 211 delegates ranged in size from 63 for the Registered Nurses' Association of Ontario down to 5 for the Association of Nurses of Prince Edward Island.

DR. JOHN B. HARDIE, M.A., B.D., Ph.D., professor of Old Testament literature at Pine Hill Divinity Hall, with a delightful Scottish burr, delivered a memorable keynote addresss. Since he spoke from scanty notes only, there is no text to share. He noted that though many professions claim to be the oldest in the world, the *art* of nursing is as old as mankind itself. Throughout the Old Testament there are frequent references to care in times of illness. Of the three factors that have profoundly influenced nursing, *religion* — embodying the cherished desire to serve others — has been most potent. It is reflected in the names given to hospitals that started as "hospice" set up to care for ailing pilgrims to the Holy Land — Hotel Dieu, St. Bartholomew, St. Paul, etc. Nursing is religion in action, the acceptance of responsibility for the well-being of others — physically, socially, mentally and spiritually.

War has been the second influencing factor in the development of nursing ideals. Modern nursing had its genesis in the lessons learned in the Crimea. It came of age in later wars when, "there was a tendency to brutalize everything in humanity." Nursing demonstrates that "not even such devastating wars could wipe out the inherent greatness of human nature."

Science, the third factor, has virtually eliminated many of the diseases that had plagued mankind for thousands of years. Surgical techniques of today are very different from the fumblings of a century ago. "When you contrast the old practices with those of the present you see how far and how fast humanity can advance . . . This is how the nursing profession can teach a lesson in faith."

Afternoon Session

Re-read Miss ALICE GIRARD's presidential address, published in our

August issue, that opened the afternoon session. The accomplishments of the biennium that she noted were further emphasized in the general secretary's report which Miss Stiver highlighted.

1. The total membership of the Canadian Nurses' Association has soared from 28,350 in 1950, to 57,165 in 1960 — more than double! As of December 31, 1959, the actual membership was: Honorary — 15, active — 51,387, associate — 5,763.

Comment: More and more the CNA is becoming representative of all graduate nurses in Canada.

2. After many years of urging and pressure from various interest groups in nursing, the CNA Retirement Plan came into being in January 1959. Eighteen months later, only 238 nurses were enrolled in this excellent means of providing for their own comfort and security at retirement!

Comment: "Why are there not more enrolled? We believe it is because nurses do not know about the plan, do not understand it . . . We ask each CNA member to talk about the plan, ask other nurses about it, discuss it in chapter meetings."

As treasurer of the association, Miss Stiver noted that, despite careful planning, it had not been possible to keep the expenditures within budget allocations and the biennium would close with a sizeable deficit. Miss Carpenter, chairman of the finance committee, then presented urgent and valid reasons for the acceptance of the proposed increase in the affiliation fees paid through the provincial associations. No vote was taken on this question at this time as it seemed essential to provide a broad understanding of the anticipated developments in the national association following discussion of the recommendations included in the Pilot Project report.

To top off the first day's program, his worship, MAYOR CHARLES A. VAUGHAN, resplendent in his chain of office, welcomed the nurses at a garden party given by the City of Halifax. The Shearwater Navy band provided stirring background music.

TUESDAY

Morning Session

In 1956 the Canadian Nurses' Association, meeting in convention in



ISABEL STEWART, PEARL MCIVER AND ELIZABETH SMELLIE

Winnipeg, formally voted to undertake the research project now so familiarly known to us as the Pilot Project. In September, 1957, Miss HELEN MUSSALLEM was appointed director of the Project and, in the intervening months, has guided it to a successful completion. This entire day was devoted to the report on the project.

As former chairman of the task committee directed to look into ways and means of setting up a program of accreditation and latterly, as chairman of the special committee appointed to assist in the developing project, SISTER DENISE LEFEBVRE discussed activities "Behind the Scenes on Accreditation." She reviewed the steps taken in laying the groundwork for the Pilot Project. Delegates shared a chuckle as the president, Miss Girard, told how Sister Lefebvre and Miss Mussallem had been affectionately nicknamed "Mother of Accreditation" and "Miss Accredidation" respectively.

Miss Mussallem's remarks picked out the highlights of her complete report and included a reading in full of the recommendations arising from the study. As she concluded it, there occurred one of those moments of deep emotion and drama that characterized this biennial meeting. With one accord the audience rose to its feet for a standing ovation that expressed warm appreciation of the exceptional personal qualities of the director, who has won friends for the Project and herself wherever she went, and acknowledged the intensive and concentrated effort

that was necessary to complete the Project within the allotted time. Miss EDNA ROSSITER, director of nursing, Shaughnessy Hospital, Vancouver and president of the RNABC, in moving that the report on the Pilot Project be accepted for discussion, helped to put into words what many listeners were feeling when she described it as a privilege to be able to do so.

Special Luncheon

Several hundred nurses gathered at the Hotel Nova Scotian to dine and to listen to DR. ALLAN B. MORRISON, director of research and curriculum with the Nova Scotia Department of Education. The guest speaker commented on the report of the Pilot Project and described it as a particularly well organized factual study. His address dealt specifically with general education, the changes made necessary and the problems that have developed as the result of accelerating scientific and technological advances over the past years. A more complex economy and culture have resulted in higher value being placed upon education. The unskilled laborer is finding it increasingly difficult to secure a place for himself.

With an acceleration in the number of children proceeding to matriculation, Dr. Morrison felt that there was less and less selectivity in the group being educated; that an attempt was being made to prepare them for more and more complex jobs in a highly technical world which, at the same time, demanded less and less individual effort to subsist because of welfare trends. In addition, essentially the same program, virtually unchanged in the past half century, was being offered to all students.

He suggested that the public schools had two major tasks. "To broaden the general educational program in a modest fashion so that provision can be made for the kind of courses required for entrance to university plus some general education courses for those who plan to enter specific kinds of training." The second task, perhaps the more important, would be to set up counselling services that would provide both parents and students with the most accurate information possible in regard to a student's ability, aptitude, interest and potentiality. His closing remarks have particular significance for nursing education:

> If we do not use our human resources effectively some other system, less free, may move in and use them for us . . . In the immediate future the person of unfounded opinions and undeveloped talents, with no sound educational foundations, has no future. In brief, if we are to survive we must adapt our educational program, revise our initial requirements, and mold our further training to suit better the young people to be educated, the jobs to be done, and the problems of living in a complicated and frustrating society.

Afternoon

From the luncheon, the nurses hur-



The Lobster Orchestra

ried to join members of their specific interest groups for a workshop session based on the Pilot Project report. For a short time, they concentrated on questions arising out of the report and affecting the various areas of nursing education programs. Directors of nursing, nursing education and nursing service were asked, for example, to consider whether administrative authority for the school of nursing and for nursing service should be vested in one person or divided between two. Since both patterns were represented by the members of the group, it proved difficult to reach a satisfactory answer. The problem of interpreting the needs of both nursing service and nursing education to a lay administrator who may lack understanding of either field, suggested to some the advisability of having one central figure — a nurse — who would also act as assistant administrator. Others, favoring divided authority, felt that both the director of nursing education and the director of nursing service should be able to speak for their respective areas with equal authority.

While supervisors strove to set down briefly the criteria necessary for evaluating nursing service in areas where students receive clinical preparation, nursing consultants, registrars and executive secretaries tried to decide how a school improvement program on a national scale might be fitted into present provincial programs. Public health nurses, staff nurses, head nurses and others, including the student nurses, faced similar questions. Shortly after 4:00 p.m. reports from all the groups were rushed to Miss HAZEL KEELER who had undertaken the task of summarizing them.

Evening Session

After a brief rest and supper, our bus drivers were once more at the door ready to take us back to the high school auditorium where DR. HELEN NAHM delivered one of the major addresses of the convention. This address will be printed as soon as possible in the *Journal.*

WEDNESDAY

Morning Session

The program listed it as "The Patient Returns to the Community"— a case presentation by a health team. Under the capable, often humorous chairmanship of DR. GUSTAVE GINGRAS we were shown the intricacies of the patient-centred approach to rehabilitation. Ably assisted by a team of workers from the Montreal Rehabilitation Centre, including a psychiatrist, a social worker, occupational therapist, and speech therapist, we learned about A.D.L. — the activities of daily living — through which the patient may be assisted to regain a level of independence following a cerebral accident. It was suggested that the audience should try to tie the shoe laces with one hand, or cut up meat! "Nurses do too much for such a patient. They need to pay greater heed to A.D.L."

Mrs. ISOBEL MACLEOD's paper discussing the need for greater cooperation between all the members of the health team will be published in next month's issue.



About to board

Afternoon

A most welcome few hours of freedom in a busy schedule! Over 400 nurses eagerly anticipated a harbor cruise while others set out for Peggy's Cove — one of the province's famous beauty spots and a favorite of artists. Starting point for the cruise was the Lord Nelson Hotel. It seemed a good idea to the members of the *Journal* staff who were among the would-be sailors, to have lunch somewhere in that vicinity and avoid any possibility of missing our buses. It must have been a good idea since so many others



On Board

shared it! However, eventually the parade of blue and white buses, led by a cheerful police escort was on its way to the appropriate navy pier. Our drivers, probably infected by the general carefree atmosphere, made good use of their horns so that doors and windows filled with curious, friendly and interested onlookers. The arrival of several hundred women caused a certain amount of disruption in naval routine as well, judging by the number of personnel who suddenly appeared at the windows of the various buildings or on the decks of vessels moored nearby.



Sea and sunshine

The trip included Bedford Basin which, during war-time had offered shelter to hundreds of vessels waiting to be convoyed across the Atlantic. The picture was very different now — one lonely vessel, belonging to the much-disputed fleet of CNR vessels, rested at anchor. Our ships then took us under the Angus L. MacDonald bridge, past tiny George's Island and on towards McNab's Island and the harbor mouth. With the help of a courteous bus driver substituting as a guide, we picked out the hidden fortifications along the shoreline that protected the harbor during World War II; glimpsed the front of the old fort built into the prominence of George's Island; were introduced to a floating drydock and much interested to note that the ship in for repairs was the *Manchester Spinner* whose captain has on more than one occasion been awarded the gold cane for opening the overseas shipping season in Montreal harbor after winter shutdown.



Lobster — mm!

The two hours went by all too quickly but with an invitation to a lobster supper at Windsor Park as guests of the Army at 6:00 p.m., there was just time enough to tidy up before the buses would be waiting for us once more. The lobster was delicious. For those interested in statistics, the line-up was estimated as being a quarter of a mile in length and at least 1200 lobsters weighing over one pound each were consumed by the hungry guests!

THURSDAY

Morning Session

For those who have yet to see the film "Hospital Sepsis" prepared by Johnson and Johnson, may we recommend it as being most worthwhile. It was presented as the first item on the day's program. This was followed by the presentation of the various national committee reports. These reports should always be of interest to every delegate since their activities are related to matters that affect us all. Far too often, the reports do not receive the attention that they deserve. A very special word of commendation for the ingenuity used on this occasion.

As a beginning, this item on the agenda was entitled the "Presidents' Conference" and the reports were presented as a panel discussion with the national committee chairmen as the experts. It was a most effective method, judging by the obvious interest of the audience. SISTER MARY FELICITAS as chairman of the committee on nursing service, reported on the completion of the head nurse manual. This will be available from the CNA in either English or French. She also noted that a pamphlet on job satisfaction, for use by employing agencies, had been prepared and was ready for use. This was the outcome of a survey to determine why nurses leave their positions and what might be done to make them happier.

Miss ETHEL GORDON, chairman of public relations, presented the "CNA Platform" which indicated how the Association intends to work toward its objectives throughout the coming biennium. The platform, which appears on page , encompassed three areas — quality of service to the public, responsibility to members and relationships to outside groups.

Miss E. A. ELECTA MACLENNAN, chairman of legislation and bylaws, commented on a number of questions studied by her group including affiliate membership with the CNA for other national associations; the status and organization of nursing assistants (this particular problem was studied jointly by nursing legislation, nursing service and nursing education); Miss HAZEL KEELER, chairman of nursing education, commented on a study undertaken by her committee in relation to the educational preparation of instructors within our schools of nursing. Miss HELEN CARPENTER, chairman of finance, emphasized the fact that these committees can only function efficiently if the funds are available to permit them to meet. During the last biennium, two committees had not been able to have full meetings because funds were not available. The subsequent acceptance of the proposal to increase the affiliation fee to the national association to $4.00 annually, assured the funds necessary for these meetings as well as other projects.

One item proposed by the Committee on Legislation and Bylaws — the formation of a Student Nurses' Unit — provoked considerable discussion and diversity of feeling from the floor. Although a number of delegates spoke in favor of forming such a national unit, the new bylaw drawn up to provide for this was finally tabled, with the recommendation that a professional member of our National Office staff should be appointed to work with the provincial student nurses' associations and to give careful consideration to student participation within our national association.

Afternoon Session

With the present emphasis on hospital insurance programs and the possible impact of such programs on nursing, it was most fitting to have this topic on the convention agenda. The HON. R. A. DONAHOE, Minister of Public Health, Nova Scotia, was the guest speaker. His theme was "The Impact of Hospital Insurance on Patient Care." Mr. Donahoe's address will be published in a future issue.

After a brief intermission a panel of nurses chaired by Miss RAE CHITTICK, director of the School for Graduate Nurses, McGill University, deliberated on the "Implications of Hospital Insurance for Nursing." In her introductory remarks, the chairman reviewed the circumstances leading to the development of hospital insurance schemes — the size of the country, varying economic conditions, uneven distribution of resources. The panel members raised several questions that must eventually be answered. To what extent are hospital commissions preparing staff before adding additional

hospital beds? How honest is it to use funds paid by the public for nursing service as subsidy for nursing education? Where should responsibility for the education of the professional nurse lie? What are the responsibilities of the nurse consultant to the hospital commission? This last question was well answered by Miss GLADYS SHARPE, senior nurse consultant to the Ontario Hospital Services Commission, a member of the panel.

Evening

The President's reception was the social highlight of this very busy day. It was held in the huge auditorium of St. Patrick's High School. The line-up of guests waiting to greet the members of the reception line was a rival in length to that seen waiting to enjoy the lobster supper! Our Nova Scotia hostesses had arranged for a most entertaining exhibition of ballroom dancing by a professional team of dancers and some of their pupils. Everyone had a wonderful time, even though many never did get close enough to shake hands with Miss Girard.



At the Reception

FRIDAY

Morning Session

It seemed hardly possible that the convention was already drawing to a close! This session had an international touch with Miss PEARL MCIVER, chairman of the Committee on Revision of Constitution and Bylaws, ICN, as the expert being interviewed at a "Press Conference." Under the chairmanship of HELEN CARPENTER, the press members attempting to stump the expert were: LUCY D. GERMAIN, executive director of the American Journal of Nursing Company; JEAN WATT, editor of the *News Bulletin*, R.N.A.O.; MARGARET E. KERR, executive director of *The Canadian Nurse*. The result was a most interesting discussion of why nursing legislation is necessary; how the professional nurse should be defined in writing legislation; what legislation provides for; how membership in the ICN is determined; who should administer nursing legislation.

At the following business session there was adequate time for the voting delegates to give full consideration to the various issues that had been discussed during the week. The report of the Pilot Project was presented for formal acceptance. The recommendations were adopted in principle and the Executive Committee was empowered to develop and implement them within the means at the disposal of the Association. This resulted in another of those moments of drama and emotion. From the area occupied by the French-speaking delegates, suddenly came the strains of "Elle a gagné les épaulettes" (She has won her epaulettes), in tribute once more to the director, Miss Mussallem. The English-speaking delegates responded with the old and familiar "For She's a Jolly Good Fellow." Most assuredly these musical outbursts established a precedent in the annals of convention business but they were spontaneous, well-deserved and heartfelt acknowledgements of the pride felt in the accomplishments of one of our members and a deep appreciation of what Miss Mussallem's efforts will mean to nursing in Canada in the years to come.

Miss KATHLEEN RUANE presented the results of the balloting for the incoming officials and members of the Nursing Sisterhoods:

President — Helen M. Carpenter, Toronto

1st Vice-president — E. A. Electa MacLennan, Halifax

2nd Vice-president — Hazel B. Keeler, Saskatoon

3rd Vice-president — Katherine E. MacLaggan, Fredericton

Nursing Sisterhood Representatives:

Maritimes — Sister Mary Irene, Charlottetown

Quebec — Sister Florence Keegan, Montreal

Ontario — Sister Madeleine of Jesus, Ottawa

The West — Sister Hugh Teresina, Lethbridge

Afternoon Session

Following a most impressive ceremony of induction, nine new honorary members were welcomed into the Canadian Nurses' Association. The record of achievement shared by this group merits inclusion in a separate report which will be found overleaf of this issue. Miss EDITH R. DICK's closing address will appear next month. With sincere appreciation for their staunch support during her administration, Miss Girard thanked her colleagues before proceeding to the simple yet moving ceremonies of installation. She felt that the convention had fittingly culminated her watchword "Faith."

Etceteras

There are so many other things that can only be mentioned briefly. This year National Office, with the assistance of their public relations counsel, provided a daily bulletin "The Conventional Nurse" — a most successful and much appreciated venture. Copies melted away from the desk at the entrance to the auditorium. And then there was the exhibitors' area, deluged by nurses whenever an intermission gave the opportunity. Booth attendants were kept busy explaining, demonstrating, taking orders. In the orchestra pit, just below the stage, sat the busy team of translators who provided simultaneous translation for our French-speaking members. Those of us sitting near them marvelled at the speed with which they worked. Periodically, the eye of the television camera or the movie camera was focused upon some particular feature of the program. Close to the front of the auditorium sat members of the press who provided excellent and accurate coverage for the sessions. Nor can we overlook the excitement of the nurses booked for the post-convention European tour; the enthusiasm of the student nurses who, having experienced the stimulation of one convention, were eagerly anticipating the next one; the truly wonderful hospitality shown by every Nova Scotian.

The next two years will pass just as rapidly as the past biennium. Start planning now to be among those present when the special convention train heads for **Vancouver in 1962!**

IN THE GOOD OLD DAYS

(The Canadian Nurse — SEPTEMBER, 1920)

The result of administering pertussis vaccines to children in various stages of the disease is reported. Quite remarkable results obtained by its early administration convinced the experimenter that these vaccines should have extended use and might be valuable in reducing the mortality from whooping cough.

* * *

It is said that the effectiveness of cod liver oil in rickets has been demonstrated. In human beings the calcium deposits in the cartilage are definitely demonstrated at the end of three weeks. Babies fed on a synthetic milk containing 10 per cent of fat in the form of cod liver oil did not develop rickets.

A well-known hospital advertising for graduate registered nurses for "institutional positions" offered a top salary of $72 per month plus maintenance.

* * *

Regulations adopted by an Order-in-Council provided for the registration of nurses in Ontario, following the annual meeting of the Canadian National Association of Trained Nurses. At that same convention, Nova Scotia reported that their Bill for this purpose had been defeated; Quebec reported that its Bill for registration had been accepted earlier in the year. It was also reported that the fee for registration in British Columbia was one dollar!

HONORARY MEMBERSHIPS

AT ITS ANNIVERSARY CONVENTION in 1958, the CNA conferred honorary memberships for the first time on a number of nurses who had made outstanding contributions over the years. This year nine new honorary members were welcomed. The ceremony, which was held on the last afternoon of the convention, was both colorful and moving. Behind the chair of each member of the platform party stood a uniformed nursing student who, as the name of the recipient was called, stepped forward with her and, as a final step in the presentation, pinned a pretty corsage on the shoulder of her dress. The participating students were: Joan Finch, president of the B.C. Student Nurses' Association, Royal Columbian Hospital, New Westminster; Marie Smith, Children's Hospital, Halifax; Lorraine Ann Bruce, St. Rita's Hospital, Sydney; Jean Edney, St. John's, Newfoundland; Monique Rainchaud, Ste. Justine's Hospital, Montreal; Fernande Larochelle, St. Luke's Hospital, Montreal; Kathleen Knox, Toronto General Hospital; Linda Cribbin, Toronto Western Hospital. Honorary memberships this year were conferred both upon representatives from the profession and from the lay public.

1. ETHEL MILDRED CRYDERMAN, CNA president 1948-50, has been an outstanding member of the profession both through her work with the Victorian Order of Nurses and her activities on behalf of the Association.



ETHEL CRYDERMAN



MOTHER VIRGINIE ALLAIRE

2. MOTHER MARIE VIRGINIE ALLAIRE, founder of Marguerite d'Youville Institute, Montreal, in 1934, has served as superior in several provinces and has been very active in both nursing and hospital associations.



(Annette & Basil Zarov)

MRS. CECIL MCDOUGALL

3. Mrs. J. Cecil McDougall who, inheriting an interest in hospitals from her grandfather, a former president of the board of governors of the Montreal General Hospital, went on to found the Association of Hospital Auxiliaries for the province of Quebec. She is president of the National Council of Hospital Auxiliaries of Canada, Incorporated and founder of the International Alliance of Hospital Auxiliaries, Incorporated.



(Ashley & Crippen)

Madame Justine de C. Beaubien

4. Madame Justine de Gaspé Beaubien, the founder of St. Justine's Hospital for Children, Montreal, and the president of its board of governors, has had an interest in the care of the sick that has extended over many years. The recipient of many honors, lay and religious, she is an honorary Fellow of the American College of Hospital Administrators, a member of the Conseil des Hôpitaux de Montréal, and an honorary member of the American Hospital Association.



Elizabeth Russell

5. Elizabeth A. Russell, has given outstanding service in the field of public health nursing in Manitoba. In recognition of distinctive accomplishments in this field, she was made a Fellow, American Public Health Association and an honorary member of the Canadian Public Health Association.



Isabel M. Stewart

6. Isabel Maitland Stewart, a Canadian graduate who has won international fame through her work as an author and as a director of the Department of Nursing Education, Teachers College, Columbia University. Dr. Stewart's intellectual stature, her devotion to the cause of healing, and her wisdom as a counsellor and friend have showered recognition upon her over the years.

7. Anna Mair took an active part in developing the Association of Nurses of Prince Edward Island and served as president in 1927 and 1934. She held the post of honorary executive secretary of



ANNA MAIR

the association during many of the years while she was superintendent of the P.E.I. Hospital.

8. MARION F. HALIBURTON, a past president of the Canadian Nursing Sisters' Association and a veteran of World War I, has given distinguished service in the field of public health nursing in Toronto and in Halifax.

9. MARGARET MACKENZIE, a past president of the Registered Nurses' Association of Nova Scotia and an honorary member of Canadian Public Health Association, has given outstanding service during the 30 years she was superintendent of nursing with the Nova Scotia Department of Health.

PLATFORM
of the
Canadian Nurses' Association

THE CANADIAN NURSES' ASSOCIATION is a federation of the ten provincial nurses' associations. Its primary function is to foster high standards of nursing practice to the end that all people may have better nursing care. The objectives of the Association are:

To maintain and improve standards of nursing education and service

To encourage its members to be well informed and to participate in community affairs

To promote the welfare of the nurses of Canada and to maintain unity among them

To encourage an attitude of mutual understanding with the nurses of other countries.

In working towards these objectives in this next biennium, the Association will:

1. Continue its efforts to increase the supply of competent nursing personnel and to advance effective utilization of professional nursing skills.

2. Continue to support legislation which provides for licensure of all who nurse for hire.

3. Follow the Pilot Project by advancing continuous improvement of educational programs in schools of nursing through study and evaluation.

4. Promote and encourage research in nursing.

5. Encourage, in every possible way, satisfactory working conditions and personnel policies for nurses.

6. Continue the promotion of the CNA Retirement Plan which enables nurses individually or in groups to plan effectively for the future.

7. Seize and create opportunities to interpret nursing to responsible bodies in Canada.

8. Work with allied groups and the public to meet the health needs of the Canadian people.

9. Cooperate with appropriate public and private agencies in planning for and providing health service in time of emergency.

10. Support and promote the program of the International Council of Nurses, including the international exchange of nurses, individually and through study tours.

Our President

As the last official function of her administration, it is customary for the retiring president to present the gavel, symbolic of the authority of the president, to her successor. Following this precedent, on June 24, 1960 Helen M. Carpenter assumed the highest office that Canadian nursing can bestow upon one of its members — the presidency of the Canadian Nurses' Association.

Years ago in Vancouver, a slight little girl of seven sat entranced as she watched a favorite aunt ascend the steps to receive her pin and diploma as a graduate nurse. From that moment, Helen's unwavering desire was to follow in her aunt's footsteps. Despite parental objection that she was not strong enough to endure the rigors of a student nurse's life, the dream held true and she entered the combination course in nursing offered by the University of Toronto School of Nursing and Toronto General Hospital. Following graduation, Miss Carpenter accepted a position as a staff nurse in an outpost hospital operated by the Ontario Red Cross Society. The next year she joined the staff of the Victorian Order of Nurses in Hamilton, later becoming a supervisor, then assistant director in the Toronto branch.

The award of a bursary by the T.G.H. Alumnae Association enabled Miss Carpenter to complete the requirements for her Bachelor of Science at Teachers College, Columbia University. Two years later, a Rockefeller Foundation Fellowship opened the way for further study at Johns Hopkins University. Graduated with her Master of Public Health, she returned to Toronto to assume dual responsibilities as director of nursing sservice in the East York Department of Health demonstration and lecturer in public health nursing at the University. For the past year she has been on sabbatical leave from her post as assistant professor, having been awarded the first Canadian Red Cross fellowship for advanced graduate study in nursing. When her demanding course of study at Teachers College is completed she will add Doctor of Education to her impressive list of qualifications.

The nurses of Canada know Miss Carpenter as the competent teacher who has chaired busy committees during her years as second, then first vice-president. Many also know her as a thoughtful friend for she has a great personal warmth for people. The friendships cover an expanse of years from her teen-age experience in C.G.I.T. camps in British Columbia clear across the continent to the present. It is fun to be in her company. She does not belittle the individual who is struggling toward a difficult goal. Rather, her response is like that of the Quaker "I have a concern about thee."

Photography, particularly close-ups of flowers and flower arrangements, has long been Miss Carpenter's favorite pastime. Before the days of color transparencies she had her own equipment for developing and printing her pictures. Gardening gives her deep personal enjoyment as well. A serious, prolific reader with an exceedingly retentive memory, studying is a joy.

The twenty-first president of the C.N.A., the ninth from the province of Ontario, Helen Carpenter will ably fill the shoes of her predecessors. As the implementation of the forward-looking, convention-approved program for better nursing education proceeds, we know the leadership is in capable hands.



(Ballard & Jarrett)

HELEN M. CARPENTER

The Status of Professional Women

PHILIPPE GARIQUE, B.Sc., PH.D.

This address was given as part of the program in conjunction with the 25th anniversary of the founding of Marguerite d'Youville Institute, Montreal.

TWO IMPORTANT CHANGES have occurred in the social standing of women since the beginning of the 20th century. The first, about which much has already been written, was the admission of women to professions formerly closed to them. One of the main characteristics of this change was the fact that the woman who wished to enter a profession more often than not had to remain a spinster.

The second change is of much more recent date, having come into prominence since World War II. It has been the rapid increase in the numbers of women who marry and carry out their duties as wives and mothers along with their professional activities. This represents more than just a change. It is the equivalent of what might be called social mutation. Until recent times the majority of married women did not leave their homes for outside occupations. Women who wanted a career comparable to that of men from the professional point of view, had to adjust to the demands of their chosen career by remaining single. It seemed that, since they had entered into direct competition with men for the authority and prestige of professional life, they had to accept the criteria of the male regarding professional behavior and use him as their model.

In spite of this, women who entered professions began to indicate their desire to combine marriage and motherhood with their careers. It was said by some that if such a tendency progressed, the end result would be a reversal of the traditional role of women. The danger foreseen was that the familiar balance between feminine and masculine behavior would be destroyed, and succeeding generations would suffer from tension and insecurity, unable to determine in whom responsibility for the family and for society should be vested.

This aspect requires further clarification. Consideration of the social position of women in general will provide a basis for conclusions concerning her professional activities.

Historical Significance

Contrary to the opinion of a great many people, it is not easy to define just what masculine and feminine behavior should be as related to the family and to society. Society, in general, differentiates between the male and the female but the specific society defines the respective roles slightly differently depending upon the view taken of the respective responsibilities of the male and female. History records the status of women as ranging from the highest possible level in some societies to almost total subjugation to the male in others. There is considerable variation in the status of women depending upon the social class to which they belong in individual societies. Throughout the history of humanity, class standing has been at least as important as sex in determining social position. Women in a dominant group have always enjoyed privileges that the men of an inferior group were denied. As an example, we have Plato's conversation with Socrates justifying his assignment of political duties to the guardians *and their wives* in his ideal state. Plato maintained that where differences between the man and the woman were of a biological nature only, with both sexes showing equal ability to carry out a task, then the duties should be assigned without discrimination as to sex.

This was the ideal situation in which men and women were accorded equal political status. But we should also remember that Plato's ideal state included both male and female slaves who were denied the privileges of free

Dr. Garique is Dean of the faculty of social sciences, University of Montreal.

citizens. Here we see a universal sociological phenomenon. When society separates into classes, the women of the upper social strata almost invariably have a higher social standing than the men in a lower class. In South Africa, for example, the white woman is, in all respects, considered socially superior to the black man. Still more recently, we have examples of a similar situation in the southern United States.

There is yet another way to look at the social standing of women. Aristotle used it, when in attempting to define the nature of women, he justified slavery and the political inaptitude of women on the grounds that women and slaves did not possess the full complement of intellectual ability seen in the free man. Aristotle's downgrading of the political standing of women on the basis of physical and intellectual incapacity has been accepted by a good many writers as justification for the differences between the sexes.

If it is true that variations in the status of women depend in part upon the class to which they belong and, at the same time, according to Aristotle, they are inferior intellectually and physically to the male, then they must always be in an inferior role to the male. This view has no scientific value however. Women can not be inferior to the men at each social level and still be considered superior to the men in lower classes if they themselves are members of the upper classes. Aristotle's argument is refuted. No philosopher so far has dared to impute intellectual weakness to women whose roles might be that of empress or queen. In this instance it would seem that Plato was wiser than Aristotle.

To understand the social standing of the professional woman, we should look at the activities set aside for the male and the female. This is not easy to do. There is a whole range of more or less mythical justifications and more or less arbitrary attitudes concerning these activities. Unwillingness to admit women to a profession or the belief that the married woman cannot follow a professional career are expressions of unjustifiable and prejudiced opinions. I do not mean to imply that women have been proven the equal of men in all respects. Biological characteristics undeniably determine the activities of each to a certain extent. We must determine in what ways the biological life of the woman varies from the male and estimate the possibilities for specific professional activity in each. The fundamental principle here is distribution of labor.

Distribution of Activities

In as much as every society makes use of its own specific definition of roles in establishing a division of labor, it follows naturally that if the women are looked upon as being intellectually and physically inferior to the men, they will be excluded from certain activities. It is a sociological fact that, under such circumstances, the social position of the women will be lower. In a society where division of labor is based upon other criteria and it is accepted that women have the intelligence and ability to carry out specific activities, then their social position is comparably higher. There is always a relationship between a society's definition of women's role, the division of labor, and social and professional standing.

The problem for professional women lies primarily in the prevailing attitude towards women in general. It is very interesting to observe how the conception of the woman's role can change. In Canada we can trace the change in attitude towards the working woman that has occurred from the time of the economic crisis in the '30's to the demand for their services during World War II. It is justifiable to say that the inferiority of professional status for women in some fields is related to current views about her nature as a woman. In instances where the differences between physiological characteristics and intellectual capacity have been clarified and where attitudes towards women in general have changed, the combination of professional duties with familial ones has been accepted as normal. It is only when men and women are placed on an equal footing that such change becomes possible.

The idea of the spiritual equality of man and woman has been one of the strongest forces in the emancipation of women. In Europe, Pope Innocent

IV recognized the electoral rights of men and women 14 years of age and over and gave to women one of the earliest forms of political equality. We might remember too, the abbesses in monastic institutions who were given authority over men.

In the field of law, the church of the Middle Ages did not distinguish between the standing of men and women in terms of which was paramount. Nor did feudal law. During the Middle Ages women reached a status professionally that was not regained until many years later. As an example of this, Anjou customs decreed that the married woman had the right to go to law herself concerning affairs relative to her business. The civil code of some countries today does not provide for this degree of equality between men and women. It is under circumstances where professions have attained a high level of development that women have been effectively recognized as the intellectual equals of men.

It is within the professions that science and the humanities have found a common meeting-ground. Science is distinguished by reasoning and humanism by its breadth of view. The principle characteristic of professional organization is that professional standing is dependent upon competence. When an individual has achieved the proficiency judged desirable by others in his profession and accepts the criteria of that profession, he becomes an authority himself. Attainment of competence has more to do with an individual's intelligence than his sex.

The question of the professional status of women is not a new one. It is inherent in the development of professions within a society. However, such standing can only truly be secured when society recognizes intellectual equality between men and women in relation to certain activities. The monastic abbesses, the trades women, queens, empresses, even the leaders of armies such as Joan of Arc are not isolated historical oddities. They were the first professional women. Today, we are rediscovering what peoples of other eras accepted unquestioningly.

No Superior-Inferior Relationship

One of our modern discoveries that is really basic to the social standing of professional women is that even if differences exist between the two sexes it does not place them in a superior-inferior relationship as far as professional ability is concerned. The fact that there are more men than women of science does not mean a difference in levels of intelligence. According to latest research findings, school performance and psychological tests for women are comparable in results to those of the men. Although some variations exist in verbal ability, in knowledge of certain subjects, in manual ability, dexterity and coordination, all studies confirm that there is the same level of intelligence in both men and women. When we speak of differences in ability or in professional knowledge, it is more correct to specify between one man and one woman.

Certain authorities have emphasized that the existence of differences in professional standing between men and women can be explained not by recourse to the biological nature of woman but by the presence of certain social and cultural factors and a more or less unconscious antagonism. Many of the anti-feminist attitudes found in a number of men and women have centred around the rise of women in the professions. Undoubtedly there are certain professions that do place restrictions on recruitment of women into their ranks. The governing bodies of some professions have the right to stipulate conditions of age, sex and ability of applicants. In accordance with such regulations, a woman might be denied admission for the most ridiculous of reasons based on "her delicate nature" or similar incapacity. But these same administrators would not find the duties of a nurse, social worker or housewife too tiring or too demanding for a woman! While it is difficult to determine exactly the biological limitations and cultural attributes in men and women, nevertheless society has developed a whole range of myths pertaining to what women are capable of doing. The fact that an individual is a female is no deterrent to the development of professional ability.

Sources of Conflict

Happily, when faced with the facts, even the most anti-feministic of employers gradually loses his prejudices.

This change of attitude can be observed most clearly in those fields where women are now generally accepted. As an example, to the outsider, the women in medicine have almost the same opportunities for success as their masculine colleagues. Parents willingly entrust their children to a lady pediatrician or themselves to a lady anesthetist. The difficulties arise from within the profession itself. The conflict is frequently evidenced through the relationships between the sexes. Conflicts in the medical profession would seem to be partly due to its organization — in fact, the type of structure appears to increase the possibilities of strife. There may be conflicts over the size and composition of clientèle; position within the medical hierarchy of the hospital; reputation as a consultant. Since the objectives are the same for the male and the female members of the profession, any obvious differentiating factors will become a basis for conflict. This is where we encounter one of the most stubborn of all prejudices — that the professional woman should remain unmarried.

Motherhood vs. a Career

According to the most frequently used argument, the presence of the mother is absolutely essential to the healthy development of her child and the career woman cannot devote as much time as she should to the duties of motherhood. Unquestionably, motherhood is an art of great importance; but the maternal role means much more than procreation. Sociological and psychological research has indicated that children growing up without their mothers may be sickly, less intelligent and die sooner in spite of the very best and latest in child care. While investigation has proven that the mother is a primary force in shaping the child's early development, emotionally, intellectually and physically, it should also be remembered that attainment of a well-balanced personality in adult life requires much more than just the mother's *presence*. Such development is also dependent upon intellectual and social stimulation. Those who would relegate women to the main role of procreator of children, devaluate the development of these same children. The change from child to adult calls for parents who are capable of helping their children adjust to adult social life. The mother must help her children to accept gradually the responsibilities of adult life. She can do this only if she herself understands what they are through active participation in social activities.

The true mother knows how to combine her responsibilities as wife, mother and career woman most effectively. These roles correspond in importance to those of the male as husband, father and breadwinner. The growing number of married women with careers is an indication of the success that has been achieved in combining roles. In Belgium, for example, 85 per cent of the women in medical practice, 73 per cent of those in law and 60 per cent of those in the teaching profession are married. Some difficulties still exist, it is true, but the time is past when to engage in professional practice means that the woman has to forego marriage and motherhood.

Social Status

As an illustration of the social status of professional women, let us look briefly at the situation in the province of Quebec. Contrary to general opinion, the participation of women in professional activities is not a new phenomenon. However, recently, their position has shown some changes. Under the influence of urbanization and industrialization, new fields have opened up for the French-Canadian woman and every year sees an improvement in her social standing. But Quebec still has a major obstacle in the way of future development in this respect. The civil code of the province does not take into account the sociological fact that women *do* participate in public life. According to the code, the status of the married woman is equivalent to legal servitude. Since the beginning of the 20th century there have been a number of amendments that have sought to correct this but legal authorities admit that these reforms have been only partial in nature, half-hearted in spirit and much belated. Those who devised the code originally believed that it was in the interest of

the family to leave ultimate authority and control of property in the hands of the husband. Apparently Aristotle's views rather than Plato's were followed in this instance.

It is ironic that a civil code representing the thinking of 19th century jurists should be enforced in a country where, since the founding of New France, women have taken such an important role in social development. Henri Bourassa, who was anything but a supporter of feminist movements, has complimented the work done by French-Canadian women over the years. It would require many volumes and much time to record the part played by the women of Quebec in developing educational programs, combatting illness, helping the unfortunate and contributing generally to the establishment of a proud society.

It is interesting to observe that the French-Canadian family never reached the degree of patriarchal authority that the authors of the civil code intended. Those who have made studies of the French-Canadian family are in agreement that the wife in this society has always had much more authority than her European counterpart. Not only is the emotional life of the family centred around her but many family activities are dependent upon her as well. If the man is the breadwinner in most cases, the woman is the administrator. Religious observances, education of the children and recreational pursuits are in her hands. In the French-Canadian family, urban or rural, while the father retains legal authority, decisive action is seldom taken without consulting the mother. She is always the intermediary between father and children, and on matters of a minor character, she will often make a decision independently. She has the authority, too, to punish the children and rarely delegates it to her husband.

Some Statistics

The civil code also failed to make any allowance for the activities of women in the daily life of the province. The French-Canadian woman has always worked outside her home and has been or is frequently a property owner. The number of women in the labor force of Quebec almost doubled in the years 1901-51 and their participation in public life has become most impressive. In 1951 there were 343,310 women, 14 years of age and over employed outside their homes — 24 per cent of the total labor force. Of this number, 16,000 were office workers; 77,000 were in industry; 37,000 were employed in hotels and restaurants; while the professions of teaching and nursing claimed 26,000 and 10,000 respectively. We should note, too, the increasing number of women entering profeessions that were formerly closed to them. Again in 1951, there were in Quebec 401 female accountants; 1278 female laboratory workers; almost 200 doctors, 30 lawyers and 13 engineers. These figures are steadily increasing.

The rising salary scale is yet another indicator of the part that women are taking in public life. In 1941 there were approximately 600 women in this province who earned over $2000 annually. In 1951, this figure had increased to more than 30,000. Although exact figures are unavailable, it is believed that there are presently about 80,000 women earning $2000 and over annually.

The growing importance of women in the field of education has been almost revolutionary. Within 20 years, 1935-55, the number of girls attending primary and secondary schools doubled. The number of students in the provincial normal schools increased from 2,517 in 1940 to 6,253 in 1955. Universities report a similar situation. There were 618 women enrolled at the University of Montreal in 1945. Ten years later there were 2,108 — more than four times as many. We find women in all fields — law, medicine, physical science, letters, social science. Some professions, such as the field of education and certain paramedical services, now have women in a majority.

Drawing Conclusions

What conclusions can we draw from these facts? Are the pessimists correct and will the professional woman because of her social and intellectual achievements, become hard, cold, lacking in charm or "sex appeal" to use popular phraseology. Will she neglect or lose the art of motherhood? Will she spend her life in a psychiatrist's

office, the victim of a whole series of complexes? Is her participation in public life only an outward expression of her boredom?

There is no need to waste time on the obvious superficialities of such remarks. At the most, they would indicate ignorance of sociological truths as related to the professional status of women. The very fact that each year shows an increase in the number of professional married women is direct refutation of some of the pessimists' views. A certain proportion of married women with careers may encounter problems but, in spite of this, the contribution of women socially, politically, economically, culturally, becomes ever greater and, generally speaking, both society and family life benefit. Instead of indulging in pessimism, we must look for solutions to existing problems.

In conclusion, may I suggest that the dilemma of the working woman versus the woman in the home is a false one. There is no need to attempt to determine whether or not women should take part in public life or devote themselves exclusively to their homes. We are already aware of the benefits to be had from their active participation. Our task now is to review the social and legal status of women so that they can carry out their functions without hindrance. Social legislation in a number of countries is being directed towards this end. An excerpt from the Report of the Royal Commission in Great Britain on the problems of population reveals this trend:

> It would be to the disadvantage of everyone, women, family and community, to limit the contribution of women to the cultural and economic life of the nation. If it is true that a conflict still exists between the roles of mother and career woman, this is due rather to the prejudice of those who reduce the role of the woman to procreator with a social standing inferior to those in professional occupations. It is recommended that all legal restriction on the participation of married women in duties of public interest such as civil service or education, be rescinded and it is further recommended that necessary legislation be authorized to permit married women to combine their homemaking roles with their professional duties.

While it is true that a mother must devote her attention to her children for a certain length of time, this does not bar her from taking part in professional activities or from returning to her profession when her children are older. In fact, the absence of women from professional life when they are childless or are no longer needed exclusively in the home, constitutes a burden on society. Remembering that the average life span for women is about 80 years and that most children are born before the mother reaches her 40th birthday, there is a period of at least 30 years during which many women contribute nothing to society. Therefore, any reluctance to change the status of women imposes a burden upon the public rather than contributing to the general welfare.

There must, first of all, be a change in the general attitude towards the duties of women. Up to the present, most men and women have believed that the main responsibility for social functioning was the lot of the male. It is hard to understand why men rather than women must be held accountable for war, social conflict, economic crisis. The least that we can say is that both are equally responsible.

Often, women themselves are to blame for their position in the social structure. They frequently behave in a way that puts them in a position of social dependence in the eyes of others. Here, perhaps, is a basic obstacle to full feminine participation in public life. Professional activity is a responsibility of adulthood. The attitude of women towards acceptance of social responsibilities related to economic and political life and other aspects of social life, and in proportion to those accepted by men, can account for some of their difficulty in achieving the desired status.

The future of their status is essentially in the hands of the women themselves. According to recent studies, professional competence is a main factor with women as with men in making a good adjustment to a chosen career. To obtain this competence, considerable experience in the field is a necessity, plus continuous research

and a sincere desire to advance the interests of the particular discipline. This alone will assure the future of the professional status of women.

A recent report from UNESCO also emphasizes the fact that differences based on sex alone should not be given any more prominence than those arising from, for example, difficulties in communication; that there is no such thing as an inferior sex but only a sex that has been persuaded to believe that it is in order to justify it's subordinate social position.

The Nightingale School of Nursing, Toronto

BLANCHE DUNCANSON, B.Sc.N.

A description of a projected venture in nursing education.

Two Year Program Implemented

WHEN THE Nightingale School of Nursing opens its doors this month to the first class of students, it will perpetuate the conclusion presented by the evaluation of the Metropolitan Demonstration School of Nursing, namely, when the school controls the student's time and experience for educational purposes, it is possible to prepare a nurse as adequately in a lesser period of time than the three years' initial preparation which have been required traditionally. Related to this concept are the necessary concomitants of assured financial support, adequate facilities, well prepared staff, and a governing body whose efforts and interests are directed to the administration of the school.

The school's historical genesis, while comparatively recent in origin, has been subject to a variety of influences. The demonstration project of the Canadian Nurses' Association at the Metropolitan School of Nursing in Windsor has had many and far-reaching effects upon individuals who have been responsible in any way for the conduct of schools of nursing. Therefore, it was not surprising when in 1957, the Registered Nurses' Association of Ontario was requested by the Provincial Department of Health to study and suggest a suitable pattern for basic nursing education, it formulated and approved the following recommendations:

1. That the basic professional education for nursing be a two-year program with qualifies the graduate for a diploma and registration and which meets the following criteria:
   a) A school of nursing has its own governing body
   b) A school of nursing has an advisory committee
   c) A school of nursing operates on a separate budget which is based on a definite pattern
   d) A school of nursing has a well prepared teaching staff sufficient in members to provide a sound educational program
   e) A school of nursing has control of the students' time and educational experience both in the classroom and the clinical field
   f) A school of nursing has the essential physical facilities
   g) A school of nursing demonstrates clearly defined objectives.
2. That the educational requirement of admission to the two-year program be the Secondary School Honor Graduation Diploma or its equivalent.
3. That diploma programs be set up under the following authorities: Universities, colleges affiliated with univer-

The Director of the School, Mrs. Duncanson, is a graduate of Victoria Hospital, London, and the University of Western Ontario. Her qualification for the administrative post includes teaching experience and the direction of the nursing education program at the Toronto Western Hospital.

sities, junior colleges, hospitals, and independent regional schools.

4. That public financial support be sought to implement and maintain the two-year program of basic professional education for nursing.

When, in 1959, the operational costs of hospital schools of nursing became a budgetary item to be met in the established per diem rate paid to the hospital by the Ontario Hospital Services Commission, it appeared as if the establishment of a school according to the foregoing criteria might be impossible. However, the authorities of the New Mount Sinai Hospital approached the Commission requesting exploration of financial support for a school that would not be owned and operated by the hospital, but rather would be a new entity in the community and which embraced those criteria. In its submission, the hospital board indicated it would donate property on which an independent regional school could be constructed provided their recommendations were implemented. The hospital also would place all its facilities at the disposal of the school.

Subsequent discussions ensued between the authorities of the Commission, Department of Health Nursing Branch, the Registered Nurses' Association of Ontario and the Provincial and Federal governments to assure the registration status of graduates from such a program and financial support not only for the operational costs but for the construction of the school as well. In addition, a method had to be evolved whereby money could be channelled as the school would not be owned and operated by a hospital. Underlying Premier Frost's announcement that such a school would be established in 1960 were the principles that the school would have autonomy of administration and that it would be supported by public funds.

The name of the school is significant as it commemorates the founding in 1860 of a school by Florence Nightingale. At that time a foundation had been set up in her honor and with this money a school was established in conjunction with St. Thomas's Hospital, London, England. This original school exemplified criteria for a sound nursing education program which are now being reapplied in the Nightingale School of Nursing.

The establishment of policies, standards and operational procedures as well as planning the construction of a new school building have absorbed the attention of the School's Board of Trustees, its Advisory Committee and director. The members of the Board of Trustees, whose chairman is Mr. A. J. Swanson, have been appointed by the Ontario Hospital Services Commission. Representing the Commission on the Board are Mr. Swanson and Msgr. J. G. Fullerton. Other members are Mr. Gurston Allen and Mr. O. B. Rogers from the Board of Governors of New Mount Sinai Hospital and Dr. C. C. Goldring, former director of education for the city of Toronto. There is provision for further representation on the Board by members who represent the community at large and who would have a particular contribution to make to the affairs of the school. The Board is responsible for approving the aims, policies and standards; securing finances and approving the budget; securing the interest and support of the public for the school and selecting the director.

The Advisory Committee has as its chairman, Miss Gladys J. Sharpe, senior nursing consultant with the Commission. Other members appointed to date by the Board include Miss Nettie D. Fidler, director of the School of Nursing, University of Toronto, Miss Dorothy Riddell, senior inspector, Nursing Branch Department of Health, Miss Ella M. Howard, director of nursing, New Mount Sinai Hospital, Dr. K. J. R. Wightman, professor of medicine, University of Toronto, Mr. Sidney Liswood, administrator, New Mount Sinai Hospital and Mrs. Blanche Duncanson, the School's director. The committee is advisory to both the Board and the staff of the School.

The purpose of the school is to offer a two-year program in basic nursing education, which will prepare its graduates for:

1. Registration as nurses in the province of Ontario;

2. beginning positions in nursing in the hospital or in the home;

3. admission, if desired, to post-basic

courses in nursing conducted by universities.

To achieve this purpose, the Board has appointed eight staff members, who, by virtue of their qualifications, should assure quality and variety in the instruction provided for the students. Four universities and six hospital schools of nursing have contributed to the preparation of the members whose appointments are herewith announced:

Miss JEAN BATES, a graduate of the School of Nursing, Wellesley Hospital and the University of Toronto, has had considerable experience in the field of psychiatric nursing. Miss JOSEPHINE FLAHERTY, following graduation from the basic degree program in nursing at the University of Toronto engaged in outpost nursing with the Red Cross Society. Community or public health nursing, too has been the activity in which Miss FRANCES JOLLIFFE engaged following her graduation from the Hamilton General Hospital and the University of Toronto.

Instructing in maternal and child health nursing has been the predominant experience undertaken by Miss JOAN MACDONALD, a graduate of the Toronto Western Hospital School of Nursing. McGill University was chosen by Miss Macdonald for post-basic study. Miss DZIDRA VOLTNERS had her basic preparation at the School of Nursing, Misericordia Hospital in Winnipeg. Following graduation from McMaster University Miss Voltners has taught the science courses fundamental to nursing. Instructing in the Certified Nursing Assistant's Course has been Miss NANCY WARTMAN'S activity since she completed the basic degree course at the University of Toronto.

Experience in teaching in a two-year program should be a rewarding experience for Miss HEIDI YAMASHITA, since she graduated from the program at the Metropolitan School of Nursing during the period when the Canadian Nurses' Association's demonstration was being carried out to prove that a nurse could be prepared as effectively in a shorter period of time, provided the school controlled the students' time and experiences for educational purposes. Since graduation from the University of Toronto, Miss Yamashita has been engaged in teaching. Most recently she has been assisting the Registrar of the Registered Nurses' Association of Ontario.

Frequently requested information about the school relates to the content and organization of the curriculum. Inherent in the philosophy of the school is the belief that the development of the curriculum is the staff's responsability. Therefore, this will not be detailed until the staff commence their duties in July, 1960. However, it is anticipated that the dominant emphasis in the curriculum will be on the concept of health and its preservation, as well as on the restoration and rehabilitation of the individual to an optimum state of health following illness. Teaching will stress principles in providing care of physical and emotional illnesses during the various stages of growth, development and dependency of the individual.

Outcomes which the school should achieve are improved utilization of well prepared instructors and subsequent satisfactions for this group, particularly when the primacy of education as the school's function is assured. In addition, as the students' needs are met more adequately, improved quality in nursing practice should result. It is believed, too, that the number of students recruited will increase. Thus, by improving the quality of the nurse's preparation, the ultimate beneficiary will be the individual who requires the services of the nurse.

Blessed is the man who, having nothing to say, abstain from giving us wordy evidence of the fact. — GEORGE ELIOT

* * *

Some people believe that education should always produce people properly adjusted to community life. I disagree. I think that education is intended to produce intelligent, morally strong and self-sufficient individual human beings, willing and capable of controlling and improving the machinery of living which man has created for his comfort and enjoyment.

— PHILIP, DUKE OF EDINBURGH



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Psychology and Gerontology

Sister Joseph Ovide, f.s.c.p., M.A.

The multiplicity of psychosocial-medical disciplines and of the principles embodied in them that are applicable to geriatric nursing, in and out of hospital, is worthy of serious consideration.

Introduction

Modern improvements in medicine, in surgery for the aged and in public health services have resulted in a considerable increase in lifespan. Statistics prove that the average life expectancy that was 48 years in 1900, passed the 65-year mark within half a century. As a result the average for our population has doubled from the figure of the Middle Ages.

Aim of Gerontology

Gerontology is the study of the process of aging — the causes, the consequences, preventive and curative measures. The latter combine physical, mental, social and economic aspects. The science of gerontology goes beyond the boundaries of medicine and biology and develops along psychosocial lines.

The general aim of gerontology is to help the aged to develop to the ultimate, their physical, social and spiritual potentialities in spite of the nature of any infirmities.

Related Problems

Modern society has been centered upon the adult and his functions although in recent years increasing thought has been given to the problems of childhood which has resulted in the development of pediatrics and child welfare services. Society's efforts must now be directed towards gerontology and the numerous problems of the aged.

In biological and sociological terms what is an aged person?

What are the respective roles of illness and of the normal process of growing old?

What are the potential abilities and qualities of the aged?

What are the psychosomatic consequences of retirement?

An attempt has been made in the field of medicine to define the biochemical changes that occur in the brain in association with the aging process; the varied effects of medication upon the elderly; neurological changes; the possible effect of a decreased rate of metabolism upon cerebral circulation and oxygenation.

Psychiatry and psychosociology have laid increasing stress upon behavioral changes and the emotional reactions in the aged. Recent experimental studies have been devoted to psychic changes and the phenomenon of stiffness in relation to the aging process. Industry, as its contribution, has studied the older worker in relation to his potential for productive work and the economic results of retirement.

Physical Changes

The nurse must be aware of the physical and emotional changes associated with aging in order to give total care to her elderly patients. Aging is a process of degeneration of body organs. Body and mind alike lose their flexibility. Increasing rigidity means lessening stamina in the old person so that even a slight degree of tension can produce serious results psychosomatically.

Studies have shown that the same medication can produce a broad range of individual reactions in the aged.[3]

Recent research has demonstrated some of the various changes in body structure or function associated with the process of growing old. Himwich and associates[3] studied biochemical changes in the brain of the elderly and associated behavior. Kety[3], using a nitrous oxide technique, looked for the relationship between age, circulation of the blood and oxygenation of the brain. His conclusions were that between infancy and adolescence,

Sister Joseph Ovide is director of the school of nursing, Verdun General Hospital, Montreal.



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there is a noticeable reduction in the circulation to the brain and the utilization of oxygen. In the process of aging, this reduction goes on slowly but steadily.

There are many questions in this area still to be answered. Is reduced brain metabolism the result of cell deterioration or of the psychological and sociological changes associated with aging? Dr. D. Siegal[3], Columbia University research centre agrees with the view of G. R. Cameron that pathological conditions found in the elderly may have their origin during childhood. This is likely to have a marked effect upon future research in the causes and mechanisms of disorders in the elderly.

Psychic Changes

Individual differences are also apparent in the areas of reason and the senses, in spite of the gradual decrease in sensory acuity and reaction time common to the elderly. Intellectual power tends to decline more slowly although we find that the elderly are more likely to think through analogy. This brings up the question of the most effective methods to be used in training the older worker.

The elderly often have difficulty in verbalizing their problems. This implies the necessity for constant observation by the nurse and careful recording in order to avoid a mechanical routine of care that fails to take the old person as an individual into account. Dr. K. Kees confirms this view by recommending that the nurses should add observation to their "soap and water techniques." Genetic and psychosocial factors are the cause of wide individual differences in the degree of aging so that the approach to problems in gerontology demands varied and non-stereotyped methods.

Nurse-Patient Relationships

Medical and hospital personnel have noticed that medical students and even student nurses seem to lose interest in the care of the elderly. Younger patients with their array of acute illnesses are more spectacular, more dramatic. It is only as students, medical and nursing, realize that their future patients will be composed to a larger extent of aged people whose symptoms are in an evolutionary stage and in whom disease processes are slower, that they will awaken to the need for broadening their outlook, professionally and humanely.

In caring for elderly patients, the nurse misses the glow and cheerfulness that she associates with the young. Medical orders frequently are rather numerous; the patient sometimes seems rather indifferent; the hospital, institutional and family environments are relatively unchanging and monotonous. Stimulation depends to a large measure upon the nurse herself. If she is lacking in enthusiasm, it is quite likely that her powers of observation will be less acute with the result that subtle but significant changes in behavior may escape her. Positive action and objective attitudes in gerontology are dependent upon a lively imagination while high ideals are essential in assuring adequate care. A recently published comparative study[2] shows that in gerontology supportive care (physical and psychosocial) is more suitable than the simple physical care especially in the areas of ideation, motivation and emotions. Such research proves once again that the elderly want to be treated as human beings and not as inanimate objects.

General principles in gerontological care could be borrowed to good advantage from the work of Helena W. Render, a psychiatric nurse.[5] She has pointed out that one of our chief functions in nursing is to help our patient to control his environment, and as a prerequisite we must have sensitivity to the subjective aspects of behavior. These principles are based upon reason and tolerance and the aim of treatment is to foster understanding.

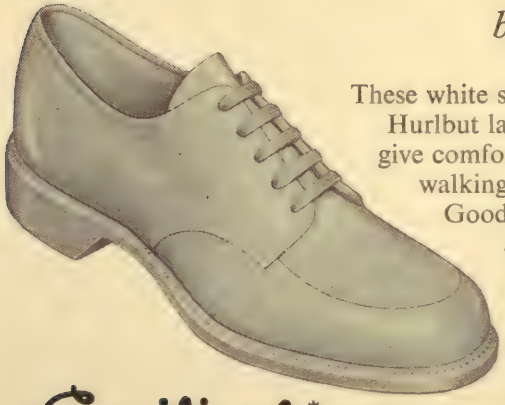
The ability to help others is really dependent upon the principle of respect for human personality. The nurse must avoid imposing her solution to problems, her ideas, her moral views upon the elderly. She must respect the right of the elderly patient to be himself, to make his own decisions and plans in accordance with his needs, his environment and his abilities. The nurse should listen, guide, assist, encourage and motivate. She must reassure the aged person concerning the usefulness of his life. These are all fundamental principles in nurse-patient



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relationships in the field of geriatrics.

Motivation

Doctor Copping[5], has commented on decreased motivation in the elderly and the consequences, both physical and emotional, resulting from it. Spiller[3], a neurologist, also recognizes the unfortunate mental effects that may result and provides a therapeutic key when he notes that action absorbs anxiety. Motivated activity does more than this. It is conducive to happy, independent living that safeguards the dignity of the elderly. It keeps the human spirit lively and active by avoiding the results of feelings of frustration, insecurity and rejection.

Aging represents fulfillment. The elderly must be made conscious of their unique role in society, their freedom, their dignity and their ultimate purpose.

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COR TRIATRIATUM

Judith Aird

This is the report of an unusual surgical condition that can be corrected because of new developments in operating room equipment and techniques.

The meaning of this rather awesome title is quite simple. It refers to a heart with three atria. The left atrium is divided by a septum into two chambers — a posterior superior which receives blood from the pulmonary veins and an anterior inferior which leads from the former to the mitral valve and left ventricle. The septum may contain one or more apertures which vary in size, or it may be imperforate in which case the infant is stillborn or dies in the first few minutes of life. Since this septum causes an obstruction at the atrial level it can simulate symptoms of mitral stenosis. It is eminently suitable for surgical treatment, yet only a few successful cases have been reported.

A case of cor triatriatum was diagnosed on an 18-month-old boy at the Montreal Children's Hospital. This was unique, since the diagnosis is usually mitral stenosis until the operation is performed and the third atrium is discovered. The child was brought into hospital May 19, 1959. His mother, a nurse, reported that the baby had had dyspnea on exertion for six weeks. His respirations were rapid and there was slight indrawing of his ribs. There was some cyanosis of his lips. These symptoms appeared only after exercise and never at rest. There was no clubbing of his fingers or toes, no venous congestion or ankle edema. A chest x-ray showed evidence of left atrial enlargement, which was moderate in degree, with secondary pulmonary edema. Digitalis was started and a cardiac catheterization was performed. The pulmonary pressures were grossly elevated. It was decided that early surgery was indicated as the child was going into heart failure. The operation was performed June 2, 1959.

An open heart operation was carried out — that is, the child was placed on the pump-oxygenator, or as it is popularly known, the heart-lung machine, for 30 minutes. After exploration, the surgeon excised the mem-

Miss Aird is on the staff of the Montreal Children's Hospital.



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brane that divided the left atrium into two chambers. Thus, obstruction to the pulmonary venous return was removed and normal circulation was possible. The operation appears to be a very simple procedure, but actually this was the only child ever to be operated on successfully at that time for this particular condition. Four other successful cases that had been reported were done on individuals in their teens and early twenties, the youngest being 17 years of age.

Nursing Care

The unit in the recovery room was set up with a tele-thermometer, a stethoscope, a blood pressure cuff, a chest aspiration set, two Kelly forceps, a dressing set and an extra drainage bottle. A high humidity oxygen tent was placed nearby. The bed was prepared with flannelette sheets and taken to the operating room. A portable oxygen tank was connected to the bed for the move to the recovery room.

The child arrived accompanied by almost the entire "heart team." He had a cut-down through which blood was running and there was one intercostal catheter in his right chest. As soon as the baby reached the recovery room he was placed in the "Croupette" with 45 per cent oxygen content. He was breathing easily. Respirations were 32 per minute and there appeared to be some cyanosis. It was impossible to attach significance to this cyanosis, however, because of the blue dye injected during heart catheterization four days previously. The level on the bottle of blood was checked and the level of the drainage bottle was noted. This was done for the purpose of calculating the amount of blood lost, as it was replaced during the first postoperative day, volume for volume. His temperature was monitored continuously by the indwelling tele-thermometer in the rectum. An electronic recording instrument (Polygraph) was used to record blood pressure. His pulse was 116, strong and fairly regular. His blood pressure was 115/50. Within an hour it had risen to 125/50 and the recordings on the Polygraph showed that it was remaining constant. When the reading was taken by cuff, the blood pressure was 90/50.

Usually there is a discrepancy between the Polygraph and the cuff readings. This instrument is especially valuable when the blood pressure is not easily obtainable by cuff. The venous pressure was recorded by the nurse using a manometer for six hours after surgery. It was erratic even though the patient was not restless. The chest tube was checked frequently to see that it was draining satisfactorily. On the second postoperative day the tube was removed. In all, 180 cc. were lost and 130 cc. given to replace this loss.

The antibiotics received by the baby were streptomycin 250 mgm. twice daily and procaine penicillin 300,000 units twice daily. Crystalline penicillin was placed in each bottle of intravenous 5% glucose and water.

The baby had to be suctioned fairly frequently for several days since there was considerable mucous secretion. His appetite was not impaired by the operation. He ate junior fruits and pablum with relish the day after surgery. His intravenous infusion was discontinued on the first postoperative day.

Later that week the surgeons and the cardiologists decided that the baby no longer needed the intensive care provided in the recovery room. He was sent to a general surgical ward on his fifth postoperative day.

Summary

This case is reported to emphasize: 1. That this was the first reported case of cor triatriatum to be corrected *in infancy and childhood;* and 2. that in this lesion the pump-oxygenator is literally life-saving and permits the corrective surgery necessary to ensure normal life expectancy instead of early death.

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THE WARD WORKBOOK

MARY M. CONROY

This is a solution to a problem related to effective learning.

Encouraging student nurses to study and to take legible notes during ward clinics is always a problem. Our faculty and students decided to investigate and see what could be done to minimize the senior students' frustration at trying to study for registration examinations from fragmentary notes half-heartedly scribbled during a clinic.

The students felt that, because the clinics were patient-centred, they missed much information if they tried to take notes. However, they felt that they needed something from which to review. One student remarked that being able to recall a particular patient and how he was nursed, as discussed in clinics, helped her to formulate nursing care plans for other patients and also to answer examination questions. Discussion with other students revealed a similar situation.

The teaching staff was concerned about the fact that many of the student nurses did little studying off duty. They felt that some means should be found to encourage them to develop what our faculty likes to call a "scientific curiosity" and to do research on their questions and problems themselves. The clinical instructors were interested in helping the student to concentrate her entire attention on the patient being discussed at the clinic. They felt that many students attempted to record the discussion verbatim.

Accordingly, the curriculum committee introduced a brief course in note-taking in the preliminary term with some success. However, we still felt dissatisfied and realized that something more was needed. Our final solution was to devise a notebook for the students along the lines of a workbook. It is called the "ward workbook" and is in use on the medical, surgical, urological and gynecological units. We examined several commercial workbooks, but felt that none would meet our particular needs nor fit easily into our clinical program.

The faculty members held several meetings and discussions to work out a plan of topics and conditions to be included. These were based on the subjects taught in the class "blocks" and the previous experience of the students. We used as our guide the curriculum outline published by the RNAO. Each instructor took a section and drafted sample questions and assignments. These had to be worded so that they could be used in relation to various patients suffering from the same condition and so, of necessity, tended to be generalized. The sample questions were mimeographed and used on one unit for a month. Both the instructor and the students were enthusiastic and so work went ahead on a complete notebook.

The questions and assignments were organized according to body systems for easy reference and graded according to the level of experience of the student. We decided to prepare no more than 12 short questions per topic. It was to be stressed to the students that these questions represented only a skeleton on which to build their own notes. The questions were directed so that most of them could be answered from information learned during the ward clinic but a few in every topic required the student to do individual study and research. The students have ward clinics twice a week. An assignment is given each time. It is completed in pencil and given to the instructor who corrects it and discusses errors or misconceptions. The corrected worksheet is then filed in the student's workbook.

The format of the workbook is designed to aid the student in studying and to encourage her to follow up her own interests. Sufficient space is left for answers and the back of the page may be used for additional notes, diagrams, bibliography and comments. The pages are mimeographed and there

Mrs. Conroy is clinical coordinator at St. Joseph's Hospital, Sudbury, Ont.

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is only one topic on each so that we may revise any section at any moment without loss of time, energy and money. The pages are looseleaf notebook size with perforations for easy insertion in standard three-ring covers. They are numbered and an index is provided for easy reference. Students receive their workbooks as soon as they are ready for ward practice.

The workbook has been in use now for over a year. We feel that some conclusions may be drawn on the basis of students' remarks and teachers' comments. Some of the advantages are:

Provision of a reliable, patient-centred outline for review purposes; all notes taken in clinics are in one convenient place; the student can see and understand the pattern in her ward classes and thus the classes are more meaningful to her; organized material is more easily learned and retained; when the student completes the assignment she gains satisfaction from her clinics.

The teachers feel:

That the students are more interested and attentive during the presentation; that the assignments are a more valid means of evaluating the student's understanding of theory than tests; and perhaps the most tangible though not the most important evidence of all, that the students have, on the whole, achieved better marks on their registration examinations.

Three criticisms could be made against the workbook. Uninterested students may copy the assignment from a classmate. This, we feel, is better than the student not having any notes at all. As far as we can ascertain, copying rarely occurs. Another criticism is that ward presentations by the instructors may become stereotyped. This is unlikely since each teacher's personality is reflected in the lectures that she prepares to fit her particular situation. The third possible charge is that we are "spoonfeeding" the students. On the contrary, we believe that we are encouraging them to seek out answers and solutions for themselves. Our librarian has recorded a much greater circulation of nursing texts and periodicals since we began to use the workbook.

We believe that the ward workbook is a useful and valuable adjunct to our teaching program. In fact, we have been so impressed by the results that we have prepared and are now using an "operating room workbook."

Sample Questions

(Space is left below each question for answers.)

Diseases of the Circulatory System

Coronary Artery Occlusion

1. Describe the symptoms
2. Define myocardial infarction and describe the pathology
3. Three diagnostic aids to determine the presence of coronary occlusion are listed. Give the normal values and state the changes in patients with myocardial infarction:
   a) Temperature
   b) Leukocyte count
   c) Erythrocyte sedimentation rate
4. Electrocardiograms are also used. State how a patient is prepared for an E.C.G.
5. Treatment and nursing care
   a) In what positions should the patient be placed for the greatest relief and comfort?
   b) What is meant by "complete bed rest?"
   c) What are the nurse's responsibilities in turning the patient? In feeding him?
   d) Why is bowel hygiene disregarded for the first few days following an attack?
6. Drug therapy
   a) Why is morphine administered in coronary occlusion?
   b) Why is papaverine used? How does it affect the patient's blood pressure?
   c) Why is aminophylline used?
   d) Why is atropine used?
   e) Why is oxygen used?
   f) Why is it necessary to have laboratory control during the administration of anticoagulant drugs?
   g) What is the normal prothrombin time?
   h) What anticoagulants are used in this hospital?
7. Discuss the role of the nurse in the management of the patient in regard to his activity in:
   a) Acute phase of his illness
   b) Subacute phase of his illness
   c) Convalescent phase
8. How and what must the nurse teach the patient about physical and mental strain?



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Public Health Nursing in Newfoundland

Ruby Harnett

Any nursing service requires the degree of flexibility that permits adaptation to particular needs. The Public Health Nursing Service in Newfoundland demonstrates just such flexibility.

Public health nursing is essentially the prevention of disease, but in Newfoundland the provision of medical care is, of necessity, an integral part of the program. Public health problems are greatly aggravated by the sparsity of the population and by difficulties of transportation and communications.

Newfoundland is an island, roughly triangular in shape, with an area of 42,000 square miles. The land area is about 85 per cent of the combined area of Nova Scotia, New Brunswick and Prince Edward Island, but it has less than one-third of their combined population and one-tenth of their motor roads. A population of approximately 432,000 people is scattered in almost 1400 villages and towns of which only 30 have more than 1000 inhabitants. Some of these villages are accessible only by water.

From this brief background it can be readily understood that a program for public health nurses has to be practical, flexible and realistic. In some of the isolated communities it would not be feasible for her to carry out a stereotyped public health service when medical and nursing care might be the primary need. Consequently, to have an effective program the curative as well as the preventive aspects of medicine must be included.

History of District Nursing

District nursing started in Newfoundland in 1920 under the auspices of NONIA — Newfoundland Outport Nursing and Industrial Association. This Association started with two nurses. In 1934 the Department of Health took over the Nonia nursing centres in the outports, which then numbered six or seven. Other outport nursing centres were organized, as well as a city nursing service in the capital, St. John's. The main purpose of this service was "to further maternal health and to attend the permanent poor of the city."

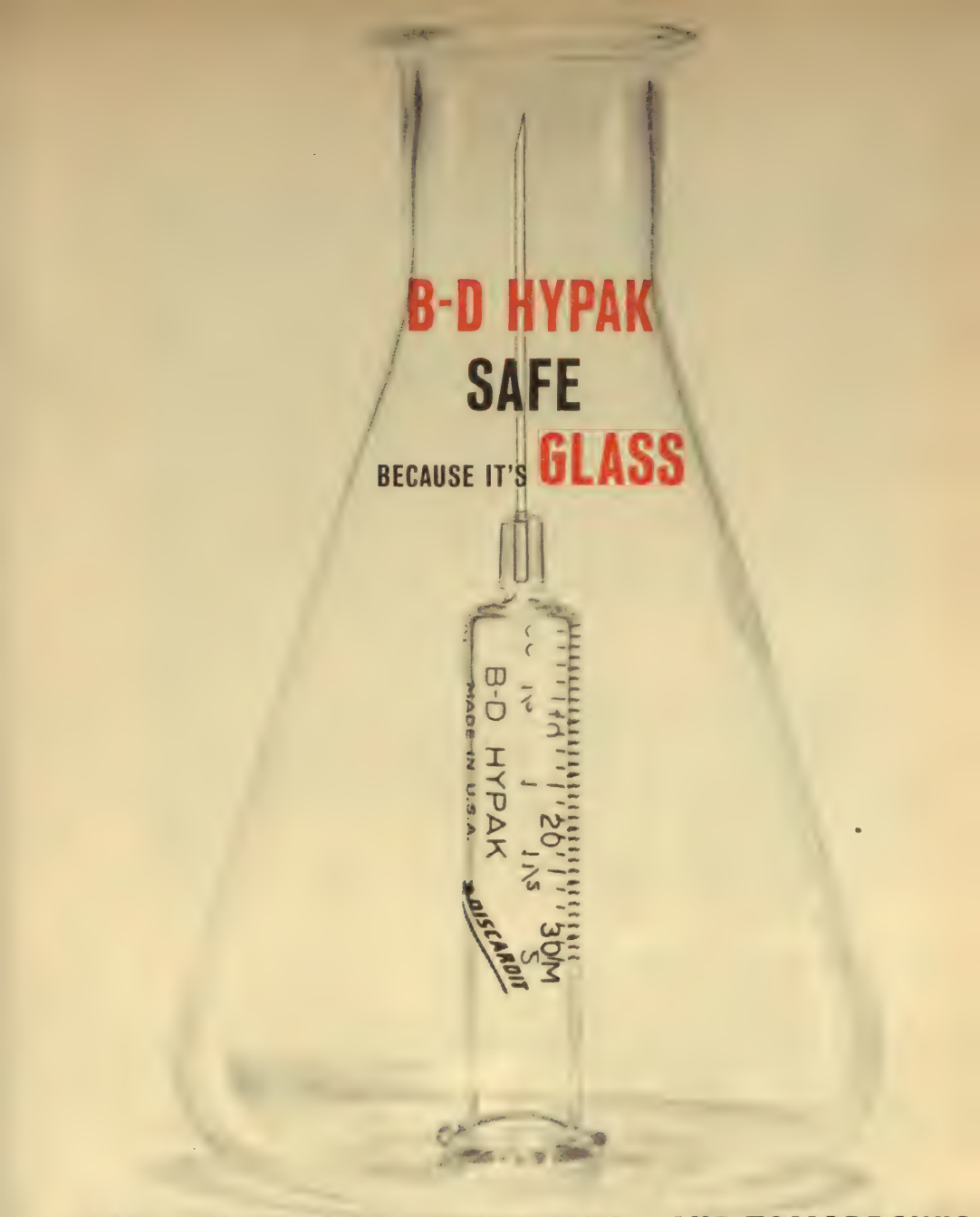
Also in St. John's the need for a child welfare service was recognized. In 1917 a child welfare program was started by a group of interested citizens under the leadership of the mayor. He donated the salary he received for that office to provide remuneration for the first visiting nurse. This was the beginning of the present Child Welfare Association, a voluntary service that receives small grants from the municipality and the provincial government. Today, this organization has a staff of six nurses and is administered by a group of 18 voluntary women. This Association carries out a very active and effective program, specializing in public health services for children from birth to five years of age.

In 1937, a Division of Public Health Nursing was set up by the Department of Health. The District Nursing Division continued its program of bedside care and maternity nursing. Prior to this the district nurses were responsible for school nursing and preventive medicine to the extent that available facilities permitted.

In 1938 the Avalon Health Unit was formed. This unit of ten public health nurses specialized in the field of tuberculosis in a concentrated area, the Avalon Peninsula. The unit was a branch of the Public Health Nursing Division until 1945 when it was dissolved. By this time the incidence of tuberculosis had decreased considerably with a reduction in the death rate of approximately 50 per cent. These dramatic results demonstrate the valuable contribution of this group of public health workers in a specific field. Today the reduction in the tuberculosis death rate is 90 per cent.

By 1940, employment had increased

Miss Harnett is associate director, Nursing Service, Department of Health, St. John's, Newfoundland.



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and the economy improved so that there was less work for the District Nursing Division. In many cases the district nurses and public health nurses were visiting the same homes — sometimes the public health nurse visited a tuberculosis patient or school child, while the district nurse attended an obstetrical, medical or surgical patient on the same day. This evidence of overlapping resulted in the amalgamation of the two services in 1941. Thus the present organization of the Public Health Nursing Service was created.

During the years from 1934 to 1946 the Public Health Services expanded considerably. With the provision of more facilities and more qualified personnel the total health program throughout the Island was improved.

Victorian Order of Nurses

With the exception of the services of the Victorian Order of Nurses, public health nursing services are administered and financed almost entirely by the Provincial Department of Health. There are two V.O.N. branches in Newfoundland. The small unit in St. John's was organized in 1954. This is a bedside care program only, carried out by three nurses. On the west coast, in Corner Brook (population approximately 23,000) there is a small unit which provides a school health service as well as a bedside care program.

Provincial Public Health Nursing Service

This Service includes: a director, an administrative staff of an associate director, an educational director and four field consultants. Within this organization, which includes the administration of 18 Cottage Hospitals, there are approximately 45 public health nurses in St. John's and 32 stationed in the outport areas.

The St. John's program is general, covering all phases of public health and providing bedside care in the homes of the indigent. The specific types of service offered are:

Morbidity Service: This is carried out by a group of ten to twelve nurses who are commonly called district nurses because the city is divided into district work areas. They give medical and bedside care to indigent families, including children, under the direction of a medical health officer.

Tuberculosis Control: The program is carried out with the close cooperation of the Newfoundland Tuberculosis Association, a voluntary organization. All diagnostic and treatment services are free to all residents of the province. The Tuberculosis Dispensary in St. John's serves as a centre for tuberculosis control in the eastern half of the province. There are five nurses attached to this centre who are in attendance at daily chest x-ray clinics and carry out a home visiting program. The out-patient department of the West Coast Sanatorium in Corner Brook serves as a similar centre in the western half of the province. The B.C.G. vaccination program was started in 1951 and is directed by the Tuberculosis Dispensary. This service is available to all children from birth to 21 years of age. Four nurses make up the team.

Venereal Disease Control: There are two nurses in this division who work directly under the Chief Medical Health Officer in V.D. clinics and visit contacts upon referral from other agencies.

Communicable Disease Control: Under the direction of the Chief Medical Health Officer, the program has the assistance of medical health officers, public health nurses and inspectors from the Health Inspection Division in St. John's. The service is free to all residents of the province who are encouraged to avail themselves of it. Within St. John's the schools are visited periodically by the public health nurses. All children are examined for acute communicable diseases and immunizations, including Salk Vaccine are kept up to date. The Child Welfare Association administers toxoids to infants and preschool children at home and in the Child Welfare clinics in St. John's and nearby areas.

Maternal and Child Health Program: This service includes prenatal clinics, held twice weekly with a doctor and public health nurses in attendance; prenatal and postnatal visiting in the home; a home confinement ser-



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vice (now practically non-existent as most deliveries occur in hospital) and prenatal classes, held weekly for expectant mothers who have been recommended by their physicians.

School Health Program: Generally speaking, the school health nurse takes over health supervision from the Child Welfare Association when the children enter school. On admission, they are given physical examinations by the school medical health officer, or if preferred, by their own private doctors.

The school health nurse makes regular visits to the school and carries out routine procedures including rapid classroom inspections when necessary. Immunization is one of the important phases of this program, as approximately 80 per cent of school children receive all their immunization requirements through the school team.

An active dental health program is carried out in the schools, with free remedial treatment provided for specific age groups.

The school health service is extended to all 38 schools in St. John's — a total school population of approximately 24,000. Working relationships between the schools and the public health nursing service are excellent thus laying a good foundation for carrying out an effective program. Nurse-teacher conferences are held frequently and specific cases are referrd to the nurse, school medical officer or parents. The nurses do follow-up home visiting when necessary.

Outport Nursing: A similar program exists wherever possible in the outport areas. Very often the nurses are stationed in settlements lacking physician's services and a great deal of their time is taken with curative nursing—bedside care, medical and surgical treatment in the home and in the clinics and home confinements. Here too, in recent years, the number of home confinements has decreased considerably.

Most of the nurses work within a cottage hospital area where they can get medical direction from the doctor in charge, but distance, time and the elements are sometimes big factors. Consequently, on many occasions, these nurses have the added responsibility of determining the causes of illness and giving temporary remedial treatment, pending the arrival of the doctor or transportation to take the patient to the hospital.

Many of the nurses employed in the outport areas have come from the United Kingdom and, generally speaking, they seem to find small community life stimulating and gain a satisfying experience in their diversified role as a leader in striving to promote a more healthy community.

Health Education

Health education is acknowledged to be vital to all public health services and an integral part of the public health nurse's program whether she works in an outport area or in a city. Health education is emphasized during the orientation and inservice training of all public health nurses.

In recent years there has been a steady increase in the nurses' use of health education materials and consultative services in health education and nutrition.

Conclusion

From this brief account of public health nursing in Newfoundland it can be readily seen that the program is completely generalized in the true acceptance of the term. It must be remembered that the development of public health in this province is comparatively recent and that many of Newfoundland's challenges have been met in a relatively short span of time. The curative aspects have often taken precedence over the preventive, but when striving to meet an objective the immediate problems must be grappled with first to ensure a firm level on which to build a sound program. It is hoped that this province has now reached that level and is ready to aim for new goals for optimum health for all.

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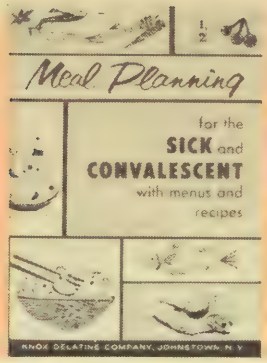
hypertension

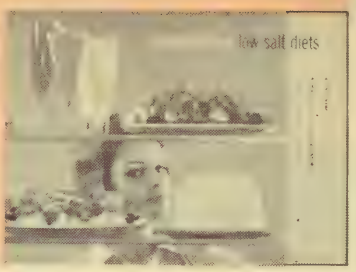
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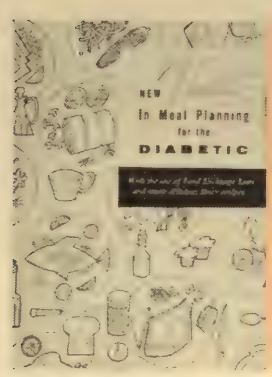
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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc. and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.





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74 STANLEY AVENUE, OTTAWA

Daily Bulletins

A special note of thanks is here expressed to Miss GENEVIEVE LAMARRE, director of nursing education, Hôpital l'Enfant - Jésus, Quebec, and Miss JEANNE BERTRAND, Assistant-registrar ANPQ for the generous contribution of their time and energy during the Convention for translating the daily bulletins.

Were you there?

If not, you will enjoy reading our editors' interesting account of the Convention activities. All reports indicate that the meeting in Halifax was a pleasant and useful experience.

Business Firms

Our thanks are very sincere to these business firms for their generous contribution to the success of the 30th Biennial Meeting.

The T. Eaton Company Limited, who again provided the attractive programs for the CNA General Meeting. The cut on the cover was provided by the Halifax Tourist and Convention Bureau.

This year Henry Birks & Son of Halifax who provided us with the folders for convention material.

Smith, Kline and French for the $200 donation towards the entertainment fund and also for the programs for the President's reception at St. Patrick's high school auditorium.

Texaco of Halifax — contribution of $50.00 for the flowers used at the Special Luncheon at the Nova Scotian Hotel.

The Island

A two-day post-convention meeting of the Executive Committee was held in Charlottetown. The newly elected President, Miss Helen Carpenter, presided.

Many social events were arranged for the Executive's entertainment including: a luncheon at Dalvay as guests of the provincial government, with the Premier as host; a luncheon at Charlottetown as guests of the city, at which the Mayor extended a welcome to all; high tea at Government House; an evening reception at Charlottetown Hospital; and a wonderful lobster buffet supper at Cavendish as guests of the Association of Nurses of Prince Edward Island.

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1. A.M.A. Journal of Diseases of Children, 95:109-119 1958

*Minimum daily requirement for this nutrient has not been established for the ages indicated.

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NIAGARA FALLS—CANADA

EXTRADURAL HEMATOMA

KATHLEEN A. DOONAN

A good rule to remember in dealing with the individual who has received a blow on the head is that the symptoms of serious difficulty may not be immediately discernible. Constant conscientious observation is of the utmost importance.

IT WAS SATURDAY EVENING. Many of the town's citizens were settling down to read the weekend paper. Meanwhile, at the city bus terminal, an accident occurred. Tom Mann, age 17 years, a "truck jumper," employed by the local agency of a daily newspaper, fell off a delivery truck as it lurched forward.

Admission to Hospital

The boy was admitted to the emergency room of the hospital in a semi-conscious state. He was able to answer briefly when questioned, but could not offer any information about his accident. The provisional diagnosis was cerebral concussion.

He appeared to be in a state of shock. Extra warmth was provided by means of additional blankets on the bed. When the external temperature is elevated, the receptors in the skin transmit impulses that result in stimulation of the body's vasodilators and consequent dilatation of the arterioles. This promotes better circulation and provides the vital organs of the body with an adequate blood supply.

Physical Examination

Vital signs were checked immediately. His blood pressure was 118/74 — normal for a 17-year-old. His temperature was 95° F. by axilla, the normal being 97.3° F. by axilla. Radial pulse rate was 60 per minute. The normal rate is 80-86 for a well-developed boy of this age. Respirations were normal at 20 per minute. The physician noted that Tom's pupils were unequal in size, but both reacted to the bright light of the ophthalmoscope.

A slight contusion was found on the right side of the back of the head. Shortly after admission he vomited, which was indicative of increased intercranial pressure although it is sometimes an emotional response to shock.

Social History

It was learned from the boy's father that Tom's mother was in another hospital awaiting abdominal surgery. Naturally, Mr. Mann was very upset about the accident. The doctor assured him that the boy would be watched closely throughout the night. The father said that his son had not had any serious illnesses previously. Since Tom had been injured while at work hospitalization expenses were the responsibility of the Workmen's Compensation Board.

Clinical Treatment

Shortly after his admission a neurosurgeon was called to see Tom. He left the following orders:

1. Oxygen per nasal catheter four liters per minute.
2. Intravenous injection of 1000 cc. 5% glucose in distilled water.
3. ACTH extract, 10 cc. intravenously, to prevent acute adrenal insufficiency.
4. Nurse at the bedside constantly to observe the patient.
5. Vital signs to be checked q. 1 h.
6. Pupils to be checked q. 1 h. for equality of size and reaction to light.
7. Immediate urinalysis for sugar. (A Clinitest revealed that no sugar was present.)
8. Hemoglobin estimation and white blood cell count.

The hemoglobin rate was normal at 96 per cent. The white blood cell count was elevated from the normal 5,000-9,000 to 23,400. The immediate cause for the latter was unknown.

The first few hours passed uneventfully. The patient's nursing care consisted chiefly in checking the vital signs

Miss Doonan is a senior student at Hotel Dieu of St. Joseph, Windsor, Ont. She received Honorable Mention in the recent Macmillan Award Competition.

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and keeping him at rest. Quiet was essential because restlessness could have precipitated a cerebral hemorrhage, if a cerebral vessel had been traumatized. The next afternoon the boy began voiding involuntarily. He lapsed into unconsciousness. His blood pressure dropped to 104/60. His pulse rate increased to 96 per minute. His temperature was elevated to 101° F. per axilla. The right pupil became enlarged and both pupils failed to react to light. He became very restless. All of these changes occurred rapidly and indicated an intracranial hemorrhage. The dilation of the right pupil was especially important since it gave evidence of increasing intracranial pressure on the right side. This along with the bruise on that side of the head, helped to confirm the diagnosis.

The doctor was notified immediately. The patient had x-rays of his abdomen, chest, and skull. Tom was moved carefully in order to prevent further hemorrhage. The radiologist reported that: "there were no fractures of the pelvis and no free air in the peritoneal cavity. The lungs appeared to be equally ventilated and there were no rib fractures." Films of the skull revealed a fracture on the right side. A craniotony was considered necessary and Tom was prepared for surgery.

His head was shaved and he was given Phenergan 25 mg. as a relaxant and atropine gr. 1/150 to reduce secretions in the nose, mouth and throat; to produce deeper respirations by stimulating the respiratory centre and finally to relax smooth muscles by paralyzing the effect of the parasympathetic nerves.

On the ward, an anesthetic bed was prepared and the following equipment assembled: an intravenous stand, oxygen tent, suction machine, mouth wipes, kidney basin, tongue depressors, ophthalmoscope, sphygmomanometer, stethescope, and a drainage bottle. It was assumed that a Foley catheter would be inserted.

Surgery

The operation required approximately two and one-half hours. Sodium pentothal intravenously and nitrous oxide by mask were the anesthetic agents used. Sodium pentothal is a very potent barbiturate, and the usual stages of anesthesia may not be apparent because consciousness is lost so rapidly. It is generally in combination with a mixture of 50% nitrous oxide and 50% oxygen. Nitrous oxide does not produce untoward respiratory or circulatory effects and is a popular anesthetic.

The neurosurgeon discovered an extradural hematoma on the right side, measuring three to four inches in diameter. It was felt that the brain had not been injured in any way. The various physical changes in the patient's condition were due to the rupture of several small vessels in this region. The blood had formed a jellied mass beneath the skull.

During the course of the operation, the anesthetist observed frothy, bloody liquid in the patient's mouth, and further examination revealed the patient was developing pulmonary edema. The operation was stopped immediately and a tracheotomy was performed. It was felt that a central nervous system lesion had caused the pulmonary condition. In pulmonary edema there is increased negative pressure in the lung. This results in pulmonary congestion, circulatory embarrassment and a suction effect upon the engorged pulmonary capillaries. Therapy is directed towards lowering the elevated negative intrapleural pressure and relieving anoxemia through the administration of oxygen. In this instance oxygen did not relieve the patient's dyspnea and cyanosis.

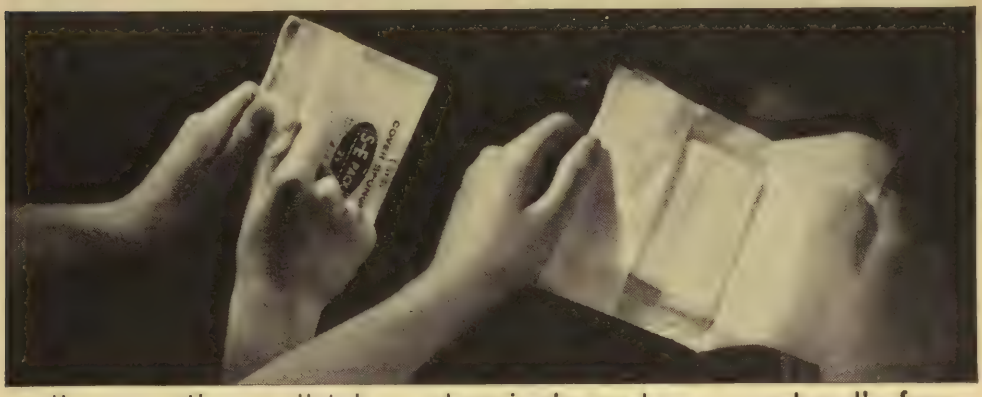
Emergency Treatment

Tom's condition became increasingly critical and his prognosis was very poor. A very large amount of bloody, mucoid material was suctioned from the trachea through the tracheotomy tube. A diuretic, Mercuhydrin 1 cc., was given intramuscularly. This is a mercurial preparation and it acts upon the kidney to depress activity in the tubules and to lessen the reabsorption of water. It also interferes with the reabsorption of chlorides (which cause fluid retention) in the tubules. As a result chlorides and fluid are excreted. Mercurial diuretics are considered to be particularly effective in relieving edema for this reason.

Atropine sulfate was given hypodermically in large doses to reduce

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1. Burnett, W. E.: *Program for Prevention & Eradication of Staphylococcic Infections*, J.A.M.A. 166: 1183-84 (March 8) 1958. 2. Adams, R.: *Prevention of Infections in Hospitals*, Am. J. Nurs. 58:344-48 (March 1958). 3. *Medical Authorities Recommend Ways to Control Infections*, Mod. Hospital 90: March 1958, 51-54.

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the rapid formation of secretions. Digoxin was given intravenously in a digitalizing dose, 1.5 mg., in order to slow and strengthen the heart beat. Digoxin is a glucoside of digitalis *lanata*. It has an advantage over digitalis for the patient who must be rapidly digitalized. When the drug is given intravenously, saturation of the tissues is accomplished rapidly, and digitalization occurs within minutes. Digoxin is a tissue irritant and must be carefully given, since it may cause sloughing. The contents of the ampoule should be diluted before administration.

Whole blood, 1000 cc. was started intravenously to replace the blood lost during surgery and to counteract shock. The head of the operating table was elevated to lessen the amount of fluid accumulating in the mouth and trachea and to facilitate breathing.

All attempts to improve the boy's condition appeared to be futile. He remained in a dyspneic, cyanotic condition. Suturing of the incision was completed and his head was bandaged. The surgeons decided that nothing further could be done and the patient was returned to his room with a parenteral infusion of 5% glucose in distilled water dripping slowly.

Postoperative Care

Tom was placed in a semi-Fowler's position in his bed. His dressing was examined and there was no apparent bleeding. His blood pressure reading was 104/50; pulse rate rapid but regular at 120 per minute; respirations, shallow and rapid, at 60 per minute. The nurses were warned to observe his eyes most carefully. If any changes in the pupils were noted, it might be indicative of another intracranial hemorrhage, and further surgical intervention would be necessary.

Postoperative Orders

1. Patient to be placed in cold croupette with oxygen running at 12 liters along with Alevaire aerosol.
2. Crystalline penicillin 1,000,000 units q.4 h.
3. Bicillin 600,000 units daily.
4. Tracheotomy to be suctioned p.r.n.
5. Foley catheter to be inserted.
6. Keep intravenous running at 10-15 drops per minute, to keep vein open.
7. Record intake and output.
8. Check blood pressure, pulse, respirations, and pupils every 30 minutes.
9. Notify the doctor of any unusual occurrences.
10. Blood chemistry as follows: plasma proteins, serum sodium, and serum potassium.

Nursing Care

The purpose of the cold croupette was to keep the body temperature down. It was important for the nurse to keep the ice container filled in order to maintain the lowered environmental temperature. Alevaire, a non-volatile substance combined with distilled water, was placed in a jar attached to the oxygen outlet in the tent. It was dispersed in a fine spray and affected the mucosa of the tracheobronchial tree directly as it was breathed in. Its purpose was to loosen mucous secretions and to keep the respiratory tract free from obstruction. One ounce of the aerosol solution was added to one pint of distilled water in the nebulizer. It was also the nurse's duty to see that the oxygen supply was maintained.

Because of the patient's elevated white blood cell count and as a prophylactic measure against further infection, antibiotics were administered. Tom was not skin-tested for sensitivity to penicillin since his father said that the boy had received penicillin during a previous illness with no allergic manifestations.

A Foley catheter was inserted and the nurse charted the type and amount of urinary output. A scanty urinary output could indicate renal complications. There was little intake for the first 24 hours. Oral intake was nil and the intravenous drip ran very slowly. An accurate output record was of great importance in determining if the amount excreted was adequate enough to reduce the pulmonary congestion.

Throughout the first postoperative night, Tom's blood pressure, pulse rate, and respirations were not stable, and consequently they were checked every 10 minutes. His blood pressure fluctuated between 126/80 and 78/58. His pulse became feeble and rapid at 136 per minute, and at one point his respirations were 70 per minute. Coramine 1.5 cc., a respiratory stimulant, was kept ready for emergency use. His



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MONTREAL CANADA

pupils remained equal in size and reacted to bright light.

One of the most important aspects of my work was the care of the tracheotomy. The tube had to be suctioned about every five minutes. Caution, patience, and persistence were needed by the nurse in her attempts to free the tenacious, mucoid material gathering in the trachea. Merthiolate was used to color the string that secured the *outer* cannula of the tracheotomy tube in the throat. This was done to prevent the possibility of untying the cord accidentally, and ejecting the tube from the trachea.

The inner cannula of the tube had to be removed and cleaned about every two hours in order to prevent any obstruction. A long-handled, tiny-headed brush was used to clean the tube. Sodium bicarbonate solution was used to loosen the hardened secretion and aqueous zephiran chloride, 1 :1000, was used as a disinfectant.

There were no marked changes in Tom's condition on the first post-operative day. Blood specimens were taken to check the patient's electrolyte balance. All were within normal limits.

a. Plasma proteins (91-108 meq./L) — 102 meq./L

b. Serum sodium (136-145 meq./L) — 140 meq./L

c. Serum potassium (3.5-5.6 meq./L) — 4.6 meq./L

The boy remained semicomatose. He was nursed in the oxygen croupette. Sponge baths kept his skin clean and comfortable. Oral hygiene was provided by frequent, regular cleansing of the gums and buccal cavity with swabs dipped in mouth wash. Intravenous feedings of glucose and distilled water provided fluid and nourishment.

On the second postoperative day, Diuril 0.5 gm. was ordered. This preparation is a diuretic and it improved urinary output and the excretion of waste products. Tom was allowed sips of water which he tolerated quite well. Early in the day he became very restless and tossed about in the bed.

Restraints were used for a time, but it was feared that the patient's constant struggle against the restraints would place a strain on the cranial suture line. The physician was notified about the patient's restlessness and ordered Sparine 50 mg. q. 4 h. as required. This produced a general dulling of mental activity, muscular relaxation, and in general had a calming effect. It was used for about 24 hours and the boy slept most of the time. It was important to change his position at frequent intervals while he slept to prevent hypostatic pneumonia and to promote good general circulation. The Foley catheter was removed on the fourth day after surgery. The nurse encouraged the patient to take clear fluids by mouth. He voided a sufficient quantity of urine within eight hours.

On the following day Tom was markedly improved. He appeared bright, alert and well-oriented as to time, place, and persons. Since very little exudate was obtained from the tracheotomy tube it was removed and the incision was sutured. No respiratory difficult followed. Upon examination the lungs were found to be clear. The rate and rhythm of the heart was normal. The white blood cell count was reduced to 5,000. The patient was definitely improved!

During the days that followed the nurse assisted in rehabilitation. She had to help the patient to understand his illness and to make the necessary physical and emotional adjustments required of him. She had to teach him to carry out the measures of self-care that he was able to do. Most of all she had to offer guidance and encouragement.

Only two weeks after surgery, Tom had his sutures removed and could look forward to going home. Thanks to the miracles of modern surgical procedures, new drugs, and diligent nursing care, a productive life would be possible for him.

In Saskatchewan, less than six years after Salk vaccine became available, 90 per cent of all children under 17 and 63 per cent of adults from 17 to 40 had had three doses of Salk vaccine.

The human race is divided into two classes: those who go ahead and do something, and those who sit still and inquire "Why wasn't it done a better way?"

— Oliver Wendell Holmes

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Parents and the Home and School Health Program

FRANCINE MORIER

Many non-nursing groups are aware of the need for community involvement in matters of health. A home and school association can accomplish a great deal toward improving the health of a community.

TO TRY TO DETERMINE PARENTS' responsibilities for health is rather like searching for the beginning of a circle or trying to explain the child's fatherhood of man! In order to shoulder their responsibilities for health, prospective parents must possess a reserve of sound physical, mental and moral health that will serve as a solid foundation on which the forthcoming generation can build. Such a reserve can reliably obtain only when individuals have lived healthfully from the beginning.

Let us presume that such is the case and that we face parenthood under these most favorable conditions. As parents, what health responsibilities fall to our lot?

The Junior High Health Education Curriculum of Manitoba states that "Health is a way of living rather than a subject to be taught." Parents therfore must live healthfully before they can transmit, exemplify or teach health to their children. The rules we were taught at school still apply.

> Adequate ventilation, exercise, recreation, rest and sleep; cleanliness, proper clothing, good posture; observing Canada's food rules; providing for elimination, safety, immunization; care of teeth, hearing and sight; care during illness and regular physical examinations.

These rules remain essentially the same during pregnancy except that a monthly examination is recommended instead of an annual one. By so doing the doctor can suggest special modifications that the mother-to-be may need to make in her regular health rules. He will be able to prevent complications or correct them if they arise.

Mrs. Morier is chairman of the Health Committee of the Home and School and Parent-Teacher Federation of Manitoba.

When children appear on the scene, how is the situation altered? To paraphrase the same Health Curriculum.

> The task of encouraging and directing the practice of healthful living belongs initially and primarily to the parents.

The health rules still apply with emphasis on adequate medical supervision from infancy such as may be obtained through well-baby clinics. Parents can keep pace with their increasing health responsibilities by maintaining good health practices in the home, by supporting school and community health programs, by discovering further health needs and helping to provide for these.

Rules are fine but, unfortunately, parents often honor them more in the breach than in the observance, as proved by food habit and dental surveys, etc. It is also true that parents cannot give their children something which they themselves do not possess, whether it be physical, mental or moral. No matter how much or how little schooling parents have had, it is their duty to:

1. Recognize health liabilities and discover what gaps exist in their health knowledge,
2. obtain the information and available assistance required,
3. carry out the recommendations of medical and health authorities.

These three objectives form the basis of our Home and School health program. We strive to promote a greater understanding of physical, mental and spiritual needs from infancy, through adolescence, to adult life. The intended outcome is an increase in good health practices in the home, support of an effective program of health in the school, solid community backing for health authorities and existing health services, and the consideration of further needs.

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*Adapted from Rebhan & Edwards[1]

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References: (1) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (2) Editorial Comments: *Canad. M. A. J.* 82:537, 1960. (3) Brownrigg, G. M.: *Canad. M. A. J.* 73:787, 1955. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844, 1957. (5) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

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The program is implemented by suggesting topics for study by local associations which relate to:

1. The maintenance of a healthful physical environment in the school and the home,
2. the health curriculum,
3. maintenance of good mental health,
4. provincial and national health services.

Health committee activities include:

1. Publicizing the fact that pamphlets, films, filmstrips and audio-visual aids are available from the Manitoba Bureau of Health Education, health units, etc.,
2. promoting cooperation with groups such as the Red Cross, Victorian Order of Nurses, health units planning prenatal clinics;
3. encouraging discussion groups for *both* parents, such as classes in home nursing, swimming and first aid;
4. developing an awareness of the need for adequate supervision of playgrounds, skating rinks, recreational centres;
5. examination of standards of safety in traffic, school busses, swimming and fire prevention in the home and community.

In summary, two words express the essence of parental and home and school responsibilities for health — *education and cooperation.* If either is lacking, health is not obtainable.

In Memoriam

Mary Ann Boyle, a graduate of St. Mary's Hospital, Montreal in 1942 died during June, 1960 at Bathurst, N.B. She served overseas with the RCAMC in World War II and upon her discharge trained as a laboratory technician. She was on the staff of the Provincial Hospital, Lancaster, N.B. until illness forced her retirement.

* * *

Mary Eleanor Cade who graduated from Hamilton General Hospital, Ont. in 1913 died in December, 1958.

* * *

Louise Cassidy who graduated from St. Michael's Hospital, Toronto in 1928 died on June 5, 1960.

* * *

Hilda (Paterson) Cuniffe, a graduate of Calgary General Hospital in 1932, died in March, 1960. She was a charter member of C.G.H. alumnae association.

* * *

Mary (Callen) Danis, a graduate of St. Michael's Hospital, Toronto in 1932, died in February, 1960.

* * *

Marjorie Edgar who graduated from the Royal Alexandra Hospital, Edmonton in 1929 died in June, 1960. A former matron of Lloydminster Hospital, Sask., Miss Edgar returned to Edmonton for postgraduate study at the University of Alberta. She was subsequently appointed a clinical supervisor at RAH, a posiition that she held for 16 years.

Florence Ells, a graduate of the Children's Hospital, Halifax in 1936, died on June 2, 1960. She was engaged in private nursing in Toronto at the time of her death.

* * *

Loretta (Archambeault) Humphreys who graduated from St. Michael's Hospital, Toronto in 1941, died November 21, 1959 in Quarreytown, N.B.

* * *

Ruth Kirk, a graduate of the Reddy Memorial Hospital, Montreal in 1941, died from injuries received in an accident, in Montreal on March 15, 1960. Her professional life had been devoted to private nursing.

* * *

Grace R. Mackenzie, a graduate of Toronto General Hospital in 1930, died July 10, 1959. She had engaged in private nursing.

* * *

Lulu Marrin, a graduate of St. Michael's Hospital, Toronto in 1921, died on December 10, 1959. Her professional life had been spent in Detroit, Michigan, mainly in service at Ford Hospital.

* * *

Bertha Eliza McGillvray, a 1903 graduate of Royal Victoria Hospital, Montreal, died in May, 1960 in New Westminster, B.C.

* * *

Roselle (Grogan) O'Sullivan, a graduate of St. Michael's Hospital, Toronto in

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*Bogash, R. C.; DeLa Chapelle, N.; Sowinski, R., and Downes, D. Disposable Type Vials for Adding Medications to Large Volume Parenterals, Am. J. Hosp. Pharm. 17:104 (Feb.) 1960.

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1923, died on March 9, 1960. She had engaged in private and occupational nursing during her professional career.

* * *

Kathleen Elizabeth Radcliffe, a graduate of Highland Park General Hospital, Michigan in 1930, died in Brantford, Ont., January 12, 1960.

* * *

Kathleen Reesor who graduated from Wellesley Hospital, Toronto in 1926, died on May 30, 1959.

* * *

Lorette Regnier, a Manitoba nurse on the staff of Misericordia Hospital, Winnipeg, died recently.

* * *

Emeline Robinson, a charter member of the Edmonton Overseas Nursing Sisters Unit who served in Belgium and France during World War I with the CAMC, died May 23, 1960. She was a past president of the Nursing Sisters' Association and served for years on the executive. During World War II she worked with the Red Cross Society, Canadian Corps and the Hostess House for service men. Miss Robinson wrote and illustrated the history of the nursing sisters of World War I. This document is presently in the Alberta government archives.

* * *

Josephine (Moore) Sandford, a 1919 graduate of St. Michael's Hospital, Toronto, died January 2, 1960.

* * *

Margaret Rose (Bridgeman) Speers, a 1929 graduate of Lord Dufferin Hospital, Orangeville, Ont., died on June 5, 1959.

* * *

Tena E. (Bailey) Stonehouse, a 1919 graduate of Harper Hospital, Detroit, died on May 23, 1959 in Windsor, Ont.

* * *

Jessie Tinney who graduated from the Public General Hospital, Chatham, Ont. in 1904, died recently in Chatham. She had been very active in the affairs of her alumnae association and was a past president. In recognition of her work with the organization, she had been given a life membership.

Book Reviews

The Nature of Retirement by Elon H. Moore, Ph.D. Edited by Gordon F. Streib, Ph.D. 217 pages. Brett-Macmillan Ltd., 132 Water Street South, Galt, Ont. 1959. Price $4.50.
Reviewed by Christine Charter, Director of Nursing, Victorian Order of Nurses, 1645 West 10th Ave., Vancouver 9.

The increasing age span of our population is resulting in greater concentration on those later years referred to as the "Fourth Stage of Life." Dr. Moore, a renowned sociologist and a man about to face retirement, presents a union of viewpoints in his book resulting from the intellectual objectivity of his profession and the compassionate sensitivity of a person to whom the problems discussed are very real.

For his purpose Dr. Moore has defined a retired person as "one who has relinquished his mid-life job or position for a life of greater freedom and leisure and who relies on other sources than wages, salary, or profits for a major portion of his current living." The problems and satisfactions of retirement are discussed for the purpose of bringing about their recognition so that intelligent planning may assist in the surmounting of many possible difficulties. Essentially practical details are discussed under such headings as: Economic preparation, investments, annuity and insurance provision, to move or not to move. Much sound basic philosophy is found in the chapters dealing with The Impact of Retirement, The Plus and Minus of Retirement, Retirement Substitutes for the Job.

Based on detailed questionnaires filled out by over 900 retired people and on close consultations with fellow social scientists, plus many formal and informal interviews, "The Nature of Retirement" is a book, broad in scope yet practical and interesting to read. Although directed mainly to the male sex one chapter is devoted to Women and Retirement. The entire book is one which would be helpful to those about to retire, to those who have already done so, and to their families, as well as to anyone interested personally or professionally in making sure that "Life has more than mere length; it has depth and breadth."

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The History of Nursing by Richard H. Shryock, Ph.D. 330 pages. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 1959. Price $5.00.

Reviewed by Miss Myrtle Crawford, University of Saskatchewan School of Nursing, Saskatoon.

This is a new book about the history of nursing. In the preface the author states that he intends not merely to retell the story of nursing but rather to present that story in close relationship to its scientific as well as its social background.

The first chapters cover the long sweep of history preceding and beginning the Christian era. The author discusses the development of observation and actions based on that observation, particularly in relation to illness, in each of the major Western (or Near Eastern) civilizations of the period. He illustrates, by examples and quotations, some of the major contributions of each civilization. Nursing as we know it is not apparent during these centuries. According to the author the main reasons for this were: that patients were looked after in the home; that the medical treatment was not of a type that required trained assistants to help with the care of the patients; that in most of these cultures the position of women was very inferior. Throughout the book these theories are put forward as reasons for lack of progress in nursing.

The considerable influence of the early Christian teaching on the care of the sick is discussed. In reference to the entrance of women into this field the author says, "Thus the heritage of hospital nursing involved a synthesis of Greek medicine, Roman institutions and Christian ideals."

The next chapters deal with the middle ages, the Renaissance and the Reformation. Progressing swiftly through the centuries we see the effect of barbarian invasions, migrations, Mohammedanism and the Arabic culture on society and on medicine. For long periods the female nurse is not active but again we see that as Western civilization advanced the status of women began to improve. The various female nursing groups, religious and secular were established.

In looking at the modern period (from 1500 to 1850) the development of medicine and the status of hospitals are considered rather fully. Developments in industry and economics, politics, science and women's rights are also reviewed. Nursing receives very little attention — although this is probably in line with historical fact. The discussion of the period from 1850 to the present includes many of the same items but nursing is presented somewhat more fully. Some of the information in this section seems somewhat inaccurate.

The book includes a large proportion of general history and history of medicine. As it was the author's intention to present nursing against this background, this seems reasonable. However, at times it appears that too much history of medicine has been included and on other occasions too much effort is expended in clarifying a point that the author is making.

This book develops rather interestingly as a story. I do not agree with the author's statement that "it will be quite possible to pick this book up where one pleases." On the contrary, I feel that much is lost if the story is not followed through from beginning to end. An interesting developmental pattern is apparent.

More clearly than certain other writers, this author distinguishes between medicine and nursing. He also identifies the emergence of the medical role of the nurse in conjunction with that of giving comfort to the patient.

Although the role of the nurse is defined quite well, this book is not specifically a history of nursing. Rather it seems to be a joint history of medicine, hospitals and nursing. If it is looked at from this viewpoint it should have some value for the teacher. It makes interesting reading for both teacher and student as it is liberally sprinkled with examples, anecdotes and quotations.

The Medical Secretary by Kenneth B. Coffin and R. Forrest Colwell. 391 pages. Brett-Macmillan Ltd., 132 Water St. South, Galt, Ont. 1959. Price $5.95.

Reviewed by Madeleine Hornsey, Clerk, Health Unit 2, Metropolitan Health Committee, Vancouver.

This clearly written, concise textbook is intended for the student who is training for work as a medical secretary, for the secretary who wishes to work in a medical office, and for the medical assistant who is expected to do office clerical work. It is written as a series of lessons covering the many specialized duties of a medical secretary in a doctor's or a dentist's office, or in a hospital.

The various tasks are clearly explained and detailed examples of many items are given. In addition to lessons in clerical duties, such as dictation, bookkeeping, billing, filing, detailed instructions are given in other duties essential to the smooth-running office: meeting patients, telephone technique, care of examining rooms and equipment. The section on dealing with unscheduled patients,

emergency calls, visiting doctors, the doctor's relatives and personal friends, and miscellaneous other visitors to the office, should prove very useful to an inexperienced receptionist. Specialized vocabulary lists and sample letters for shorthand and typing practice are included in each lesson.

Because this is an American publication, the details given in the sections regarding health insurance plans and taxes apply specifically to the worker in the United States. However, these sections are useful to draw the worker's attention to the fact that she needs to obtain information about similar Canadian plans.

This appears to be a very useful handbook for a lay person in any medical office.

Trends in Nursing History by Elizabeth M. Jamieson, R.N., B.A., Mary F. Sewall, R.N., B.S. and Lucille S. Gjertson, R.N., B.S. 522 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 5th ed. 1959. Price $5.00.

Reviewed by Miss Mary Hamilton, Winnipeg General Hospital, Winnipeg, Man.

The story of nursing unfolds with a pleasing continuity of thought. It is interpreted against the religious, social, military and political backgrounds of the times.

Nursing is traced from its humble beginnings down through the Dark Ages when only a tiny flame flickered. In spite of many setbacks, the movement gained such momentum that it is difficult for the modern nurse to realize that the present day conception of nursing and hospitals was not always such. The scope of nursing radiates out in all directions.

Student nurses will find this a satisfying story of their profession. It will prove a valuable reference book for them. It is an easily read, straightforward account of the history of nursing. The method of presentation of material is good. The shortened first chapters and the inclusion of more recent and current events in nursing were necessary revisions.

A team of Washington University scientists has demonstrated that a diseased kidney is not, necessarily, all sick. A relatively few hard-working nephrons can maintain the function of a diseased kidney near normal capacity and thus conceal the progressive damages of a group of kidney disorders known as Bright's disease.

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Registered Nurses for 44-bed hospital, salary $325 per mo. with $5.00 increments per mo. after each 6-mo. service, board & room $30 per mo., group medical & hospitalization plans available. Apply: Holy Cross Hospital, P.O. Box 339, Spirit River, Alberta.

Registered General Duty Nurses (2) immediately for active 30-bed hospital. Salary $270-$295 per mo., 40-hr. wk., 21 days vacation after 1 year, plus all statutory holidays, 1½-days sick leave per mo., room, board & laundry $30 per mo. if desired. For further information apply: Matron, Municipal Hospital, Magrath, Alberta.

Registered General Duty Nurses for busy 45-bed hospital, with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr. wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

General Duty Nurses (2) Salary $270 - $300 per mo. plus other benefits, 40-hr. wk., train fare from any point in Canada will be refunded if employed for 1-year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta. Phone 335.

General Duty Nurses for 34-bed hospital. Salary $270 with 6- $5.00 increments every 6-mo. to maximum of $300, modern residence — $20 per mo., 40-hr. wk., vacation 1-mo. including statutory holidays, M.S.I. & Blue Cross plans in force. C.N.A. pension plan available. Apply: Miss M. M. Sissons, Matron, Municipal Hospital, Vulcan, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

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Head Nurse for Medical Ward in General Hospital with school of nursing, located in the interior of B.C. Salary based on experience and/or postgraduate preparation. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Head Nurse for Pediatric Ward General Hospital with school of nursing. Able to assist with student teaching program. Salary based on experience and/or postgraduate preparation. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Head Nurse for 48-bed **Pediatric Department** with postgraduate preparation in pediatrics & preparation &/or experience as head nurse. B.C. registration required. Salary: $305-$369. Credit for past experience & postgraduate preparation. Annual increments. 40-hr. wk. 28-day annual vacation, statutory holidays, cumulative sick leave. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

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General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia

General Duty Nurses (2) immediately for 25-bed hospital 43 mi. north of Nelson, B.C. Salary: $285 to start; $270 non-registered. Living-in accommodation. Superannuation. Apply Matron, Victorian Hospital, Kaslo, British Columbia.

General Duty Nurses Salary $285 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Starting salary, 1960: $285; 1961: $312, more if experienced. Residence available. For particulars apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

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General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

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Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

MANITOBA

Registered Nurse (1-Immediately) for 11-bed hospital. Salary $310 per mo. with increments, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit, Birch River, Manitoba.

Registered Nurses for Swan River Valley Hospital. Salary $280 with 4 semi-annual increments to $300, 40-hr. wk., 3, 8-hr. rotating shifts, 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Recreational facilities include golfing, fishing, swimming, curling, etc. Apply to: Swan River Valley Hospital, Swan River, Manitoba.

Registered Nurse for General Duty, Licensed Practical Nurse. Good salaries & conditions. Apply Matron, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurses (2) for General Duty (immediately) for fully modern hospital, 36-mi. from Winnipeg. Salary: $305 per mo. less $45 per mo. for full maintenance. $5.00 increase every 6-mo. for 4 increases. 1-mo. vacation after 1-yr. 8 statutory holidays, 42-hr. wk. Apply to: Mrs. O. C. Campbell, Matron, Hunter Memorial Hospital, Teulon, Manitoba.

Registered Nurses (2) for small modern hospital situated in the Whiteshell district of Manitoba. Excellent bus & train services to Winnipeg & Kenora. **One (1) Registered Nurse preferably with O.R. experience.** Starting salary $295 with semi-annual increases of $5.00, 1-mo. vacation after 1-yr., 8-statutory holidays. Apply: Matron, District Hospital, Whitemouth, Manitoba.

General Duty Nurses (3) for new 85-bed hospital. Good salary & generous personnel policies. Apply: Director of Nursing, Portage Hospital District #18, Portage La Prairie, Manitoba.

NOVA SCOTIA

Director of Nursing for new 68-bed hospital to be completed early in 1961. Please reply to: Personnel Committee, Soldiers' Memorial Hospital, Middleton, Nova Scotia.

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing Service for modern 100-bed hospital, day duty only, salary open, excellent personnel policies. Interview will be arranged. Forward enquiries to: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

Director of Volunteers for organization & direction of an extensive volunteer program in large General Hospital. Please apply to: Assistant Administrator Nursing, Ottawa Civic Hospital. Ottawa 3, Ontario.

Supervisors (Afternoon & Night), **Registered Nurses** (Extension Units), **General Duty Nurses** (Medical, Surgical & Obstetrical Units) for new hospital in centre of Seaway valley. For applications & enquires apply: Director of Nursing, Winchester & District Memorial Hospital, Winchester, Ontario.

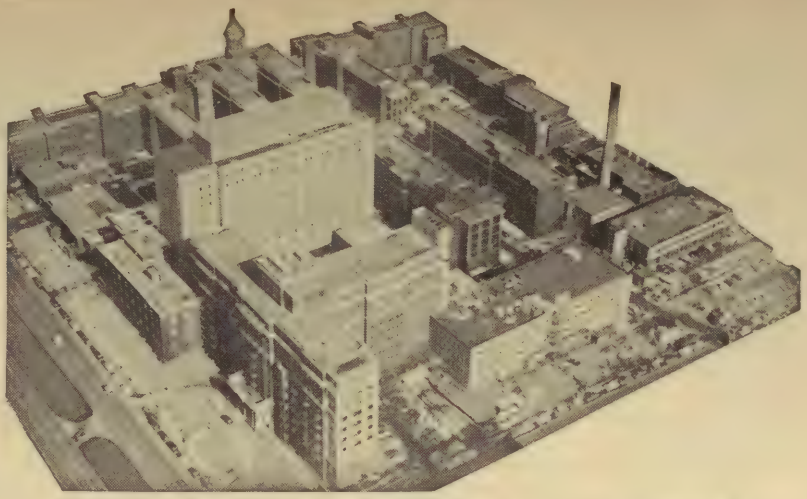
Supervisor of Public Health Nursing required by the Welland & District Health Unit. For details write to: The Director, Welland & District Health Unit, King Street at Fourth, Welland, Ontario.

Director of Nursing for modern (1957) 53-bed hospital (to be increased this year to 72). Attractive town of 5,500. Salary dependent upon qualifications & experience. Please enclose references, give full particulars & date available in letter to: Secretary, Dryden District General Hospital, Dryden, Ontario.

Operating Room Supervisor (fully qualified & experienced) Good salary, 5-day wk., other benefits. Apply to: Mr. F. P. Chaffey, Administrator, The Cottage Hospital, Pembroke, Ontario.

Assistant to Superintendent for 37-bed hospital recently opened in July. 40-hr. wk. Good personnel policies. Will be expected to relieve in Operating Room. Apply to: Superintendent, District Hospital, Kemptville, Ontario.

Instructors (Science & Psychiatry) also Head Nurse for delivery room & General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.



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WINNIPEG 3, MANITOBA

Instructor for Certified Nursing Assistant Course. Training program is 10-months. 100-bed modern hospital. **Dietitian** for 100-bed modern hospital. Excellent personnel policies & salary scale, pension plan. **Physiotherapist** for 100-bed modern hospital. Duties to commence September 1, 1960. Apply to: Sister Superior, St. Vincent de Paul Hospital, Brockville, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurse "Not-recent" graduate. Excellent opportunity. No age limit. Supervisory capacity, day shift only in modern Dental Clinic in progressive area of Toronto. Please send full particulars. Apply: Mrs. H. T. Robbins, Bayview Dental Centre, 596-598 Bayview Avenue, Toronto, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses & Certified Nursing Assistants needed to open new 165-bed wing in a 365-bed General Hospital located in suburban Toronto. Good salary, personnel policies include 5-day work wk., 8 statutory holidays. R.N. vacation after 1-yr. - 3-wks. Cert. N.A. - 2-wks. Living-in accommodation. Apply to: Director of Nursing, General Hospital, Scarborough, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Duties to commence in July, 1960. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

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Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

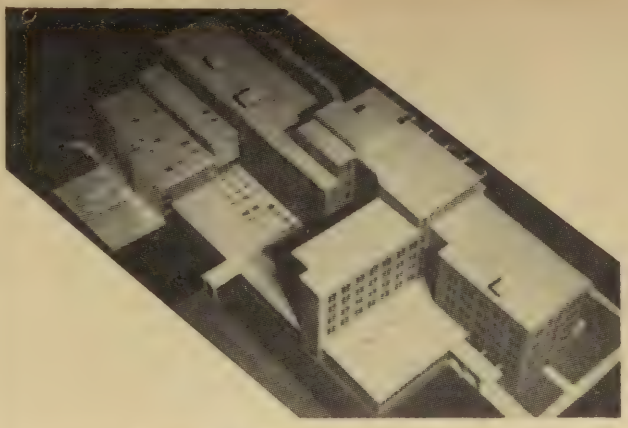
Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered General Duty Nurses (all departments) in new 300-bed hospital in Niagara Peninsula. Starting salary $270 with 3-annual increments to $300 per mo., 40-hr. 5-day wk., with 3-wk. annual vacation, residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.



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SUPERVISOR — HEAD NURSE

GENERAL DUTY NURSES (3)

FOR

5-theatre Operating Room Suite, in New Wing of 300-bed teaching hospital.

SUPERVISOR — To administer Operating, Post-anesthetic and Emergency Units. Postgraduate course and supervisory experience essential. Attractive personnel policies.

General Duty Positions available in Pediatric and Obstetric Services.

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REGISTERED NURSES

AND

CERTIFIED NURSING ASSISTANTS

The hospital is modern, fully approved (J.C.A.H.) with plans for an expansion program to be completed over the next five years.

Sarnia is a rapidly growing city located midway on the seaway, 60 miles north of Detroit and Windsor and 60 miles west of London. It is a summer resort area noted for swimming and boating as well as being located a reasonable distance from the skiing resorts in Northern Michigan.

Excellent benefits include a 40 hour week, regular rotation of shifts with premium pay for evenings and nights.

Salary Schedule:

for Registered Nurses — $265 per month to $324 per month.
for Certified Nursing Assistants — $187 per month to $215 per month.

Apply to:

PERSONNEL DIRECTOR, SARNIA GENERAL HOSPITAL, SARNIA, ONTARIO.

Registered Staff Nurses for all departments (including Operating Room); 5-day wk.; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital. Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Public Health Nurse (qualified) generalized program, salary $3,400, annual increment $200, 5-day wk., car allowance ten cents per mile, group insurance plan, 4-wk. vacation. Apply to: Dr. W. N. Turpel, M.O.H. & Director, Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurse (Qualified - Catholic) for St. Elizabeth Visiting Nurses' Assn. Minimum salary: $3,600, annual increment. 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto, 2, Ontario. EM. 8-1863.

Public Health Nurses for Staff positions. Starting salary $3,600 with uniform allowance & annual increments. Good personnel policies. Apply to: Miss Helen Saunders, Director, Victorian Order of Nurses, Windsor, Ontario.

Nurses for Operating Room & General Duty for 100-bed General Hospital. Salary: $250 - $300 per mo. according to experience & qualifications. 40-hr. wk., 7 statutory holidays, 12 days sick leave & pension fund. Apply to: Directrice du Nursing, Hôpital St-Jean de Brébeuf, Sturgeon Falls, Ontario.

P.E.I.

General Duty Staff Nurses for 12-bed hospital, 8-hr. shifts, 44-hr.-wk., room & board provided. Apply to: Superintendent, Stewart Memorial Health Centre, Tyne Valley, Prince Edward Island.

BERMUDA

Assistant Matron with postgraduate, or experience in administration nursing service, for 140-bed hospital with building program in operation. For further information apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Evening Supervisor (Experience in ward supervision as a minimum), **Assistant Supervisor** (Experience in supervision required), **O.R. Supervisor** (Postgraduate course or experience in supervision of O.R.), **Registered Nurses** (General Staff). Salary scale of ANPQ. Write to: Director of Nursing, Lachine General Hospital, Lachine, Quebec.

Registered Laboratory Technician for new modern 24-bed hospital located in centre of Gaspe Peninsula, excellent recreation facilities including indoor swimming & artificial ice. Salary commensurate with qualifications. Reply stating training & experience to: Box L, The Canadian Nurse Journal, 1522 Sherbrooke Street west, Montreal 25, Quebec.



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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

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AND

CERTIFIED NURSING ASSISTANTS

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WESTMINSTER HOSPITAL, LONDON
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Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

KINGSTON GENERAL HOSPITAL

invites applications for position of

DIRECTOR OF NURSING

The hospital is situated in the cultural and historic city of Kingston. The new Connell Wing recently opened increased bed capacity to 625. A modern, new cafeteria, with a nurses' training school completes a brief picture of this fully accredited General Hospital. Salary is dependent upon qualifications and experience. Excellent personnel policies with 4 weeks annual vacation, pension and medical plans.

For further information address enquiries to:

SUPERINTENDENT

KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

Assistant Head Nurses: excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurse for new modern 24-bed hospital located in centre of Gaspe Peninsula to be opened in August. Working conditions in accordance with Quebec Association of Nurses standards. 44-hr. wk., excellent recreation facilities including indoor swimming & artificial ice. Reply stating training & experience to Box L, the Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

SASKATCHEWAN

Matron (1); Registered Nurses for General Duty (2) for 8-bed hospital at Hodgeville, Sask. Duties to commence immediately. Salary & all benefits according to SRNA. Maintenance available at $30 per mo. Contact: Mrs. M. Rumpel, Secretary, Union Hospital, Hodgeville, Saskatchewan.

Matron (To commence duty Oct. 1), Registered Nurses (2-Immediately). Salaries as per S.R.N.A. schedule. 40-hr. wk. Nurses' residence. Daily bus service. Apply to: Fred Howlett, Secretary, or phone 53, Union Hospital, Mossbank, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi. from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Registered Nurses for Operating Room, Delivery, Nursery — all shifts. Starting salary $340 per mo., liberal shift differential, 9 paid holidays, insurance, sick leave & vacation. Contact: Director of Nurses, Washington Township Hospital, 2000 Mowry Avenue, Fremont, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Registered Nurses for General Duty, obstetrics, operating room & emergency. Beginning salary: $330 per mo. $10 differential paid for afternoon & night shifts, also for obstetrics, nursery & operating room. 40-hr. wk. Liberal vacation policy, sick leave, holidays. Paid health & life insurance. Please write: Mrs. Doretha Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses (Surgery & General Duty) for 200-bed hospital located in southern California. Beginning salary (40-hr. wk.) $345 per mo. Additional $10 for surgery & obstetrical service plus differential of $22.50 for p.m.'s & nights. Apply: Santa Ana Community Hospital, 600 E. Washington Ave., Santa Ana, California, Attn: Personnel Director.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

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WANTED

Excellent working conditions: pension plan, salary range $57 - $80 per week according to qualifications. Statutory holidays, paid sick leave, paid vacation, life insurance, sickness insurance. Free: 1 meal daily, laundering of uniforms.

For further information write to:

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MONTREAL 35

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would welcome applications for operating room technicians

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Qualified Clinical Teacher for Operating Room

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AND

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KINGSTON GENERAL HOSPITAL, KINGSTON,
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required for the

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of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

Staff Nurses for 200-bed General Hospital; heart of Los Angeles cultural & educational center. **General Duty:** $335 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays 12 day sick leave. Cotton uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever feasible. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South, St. Louis Street, Los Angeles 23, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Registered Nurses (Opportunities are available) Come to California to further your nursing career. If you are eligible for California registration & can speak & write English, the Los Angeles County General Hospital can offer you a position starting at $375 monthly. Openings now available on Medical, Obstetrical & Surgical Services. For full details, write: Evelyn Nina Spees, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Director of School of Nursing for 200-bed J.C.A.H. accredited General Hospital. State approved diploma school seeking N.L.N. accreditation. Average enrollment, 65 students. Master's degree in nursing education & experience as educational director preferred. Salary commensurate with background. Liberal personnel policies. Apply: Rev. Carl H. Grathwohl, Administrator, Evangelical Deaconess Hospital, 3245 East Jefferson Avenue, Detroit 7, Michigan.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurse — Immediate positions available in medical-surgical, obstetrical, pediatrics & operating room units of modern, non-profit, J.C.A.H. accredited 125-bed General Hospital located in beautiful suburban area just 20-min. from downtown Detroit. Progressive, expanding organization with liberal personnel policies & in-service education program. Salary commensurate with experience with differential for afternoon & evening shifts. Apply: Director of Nursing, The Lynn Hospital, Lincoln Park, Michigan.

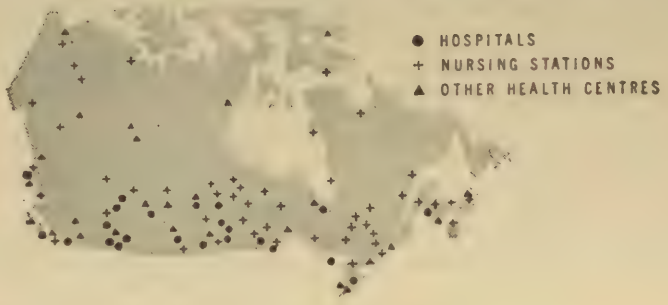
Graduate Nurses for General Hospital & Infirmary, 17 mi. west of downtown Detroit, Michigan (Choice of General or Psychiatric Duty). Salary: $410-$450 per mo. 40-hr. wk. Up to 15 days vacation after first year, plus 11 holidays. Liberal sick leave, retirement & social security. Must be graduate of accredited Canadian nursing school. Write: Director of Nursing (either General, Infirmary or Psychiatric), Wayne County General Hospital, Eloise, Michigan.

School Nurse for small infirmary in girl's private school, 20-mi from New York City., pleasant opportunity. Apply: P.O. Box 308, Summit, New Jersey.

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(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
For subscribers in Canada, in combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
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Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
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Between Ourselves

"Always some certain end must be kept in view." With that sentence as her Watchword HELEN M. CARPENTER concluded her acceptance address at the 1960 convention. We are using her remarks as our editorial this month and invite you to examine your own work, your participation in local as well as provincial and national nursing affairs in the light of our Watchword. "Some certain end" — a definite goal, a specific purpose, an end to aimless drifting — all of these are included in those three words. With as complete objectivity as possible, ponder on the implications for the future of nursing in Canada if each of us keeps "some certain end" constantly in view.

* * *

Speaking of purposes, the Executive Committee of the Canadian Nurses' Association has approved a complete revision of the objectives of *The Canadian Nurse*. This is the first time they have been reworded since their statement and endorsement by the CNA in 1934. If you have your copy of the March, 1955 issue available, our Golden Anniversary number, you will find the listing of those 1934 objectives on page 164. Here is the 1960 version:

1. To be the channel through which Canadian nurses, and others, are informed about the objectives and policies of the Canadian Nurses' Association and pertinent activities of the profession, with emphasis on national aspects.
2. To keep nurses informed on issues facing the profession and on the steps being taken to meet them.
3. To record developments in nursing service and nursing education, with descriptions of studies and research projects.
4. To provide up-to-date, scientific, accurate information relating to health and illness.
5. To provide information regarding international nursing affairs and serve as a medium for the promotion of understanding between the nurses of Canada and those of other countries.

* * *

As it was predicted in the report of the convention last month, several of the addresses presented there are reproduced in this number for your interest and information. There is historical value in the summary of the developments that led up to and supported the prime accomplishment of last biennium — the Pilot Project for the Evaluation of Schools of Nursing. SISTER DENISE LEFEBVRE spent hundreds of hours on this program over the years. She is all too modest respecting the role she played.

We hope that every chapter is planning to purchase a copy of HELEN MUSSALLEM's comprehensive report on her two years' work as director of the Pilot Project. The glimpse of its contents afforded by her address to the convention should stimulate you to active study and discussion. Why were so many of the schools of nursing found wanting, for example?

We noted that the Protestant service for convention registrants was held in St. Paul's Church, Halifax. REV. H. ST. C. HILCHEY, the rector, has graciously authorized us to reproduce the sermon which he preached at that service.

* * *

Twice before we have published the very complete summary of Clinical Laboratory Procedures prepared for us by DR. E. WATSON. Thousands of reprints of this material have been sold to graduate and student nurses. Our stock of the reprints was getting very low last spring so we wrote to Dr. Watson asking him if there were any additions or revisions he would like to make. His immediate reply revealed not only that he was delighted to go over his material and bring it right up-to-date but also that he was retiring at the end of June from his position as Professor of Pathological Chemistry and Senior Associate in Medicine at the University of Western Ontario.

The supply of reprints that is being ordered will last us for another five years, we hope. You may use the order form appearing on page 936 or send a personal letter. Be sure to specify quantity desired in either form of ordering. The prices are listed on the order blank.

* * *

After more than 55 years of being mailed in a cover of one kind or another, this month's issue has reached you with an imprinted label affixed to the front cover. The Journal Board authorized this change in the interest of economy.

We trust that the copies will reach you in first-class condition. Many publications reach us without any wrapper and show no damage. We hope your copies travel as safely!



she sleeps on the earthen floor

Nga, Vietnamese, age 4. Lives with mother, sister and brother in shed with thatched roof and beaten earth floor. Mother ill with heart disease. Cannot work. Older sister also seriously ill earns 27¢ per day. Family sold only possession . . . a bed for $2.08. Mother looks on children with despair. Help to Nga means hope, life itself to whole family. Help vital.

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City.....Prov.....

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Indications—To control ophthalmic inflammation.

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Description—A true solution of hydrocortisone-21-phosphate.

Administration—1 or 2 drops in the eye q.2h. during the day.

DECHOTYL (AMES)

Indications—To provide gentle and gradual transition from chronic constipation to normal bowel function.

Description—Each tablet contains: Decholin (dehydrocholic acid) 200 mg. desoxycholic acid 50 mg., dioctyl sodium sulfosuccinate 50 mg.

Administration—Average adult dose: 2 at bedtime. Some individuals initially may require 1 to 2, three or four times daily.

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Indications—Treatment of all forms of acute and chronic depression.

Description—Each tablet contains: Miltown (meprobamate) 400 mg. and benactyzine 1 mg.

Administration—Usually to start, 1 tablet q.i.d., increasing gradually if necessary to 3 tablets q.i.d., then reducing to maintenance level as relief is obtained.

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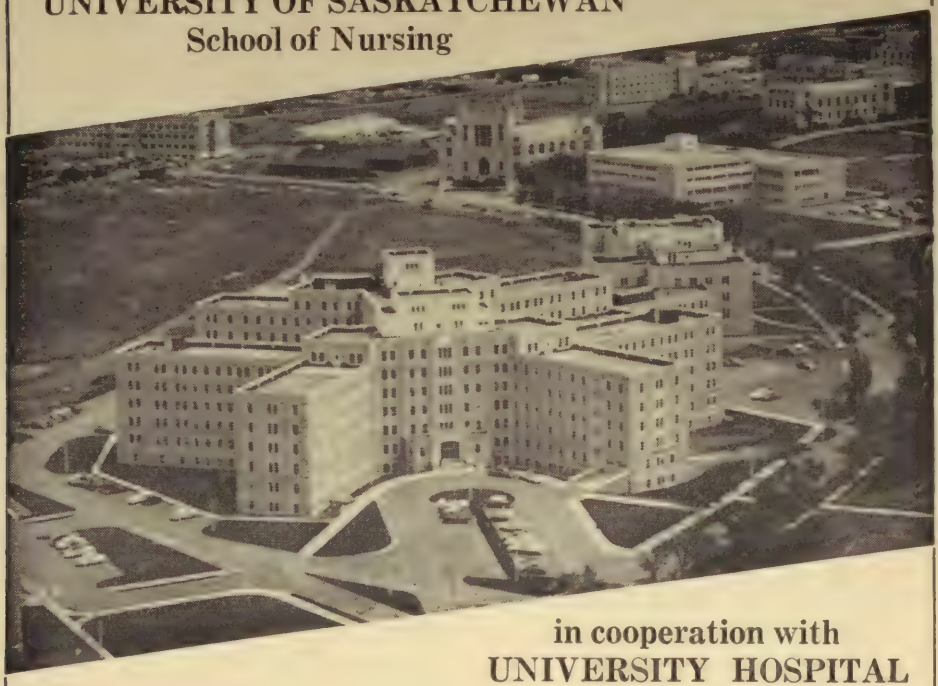
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Random Comments

Dear Editor:

While sending you my change of address may I take the opportunity of extending my gratitude for the excellent work which is being accomplished by *L'Infirmière Canadienne.*

I am always anxious to read each new issue. Congratulations and good luck.

SR. MARTHE GOYETTE, Manitoba

Dear Editor:

I have been a trained attendant since 1955. For four years I worked in a general hospital and transferred to a mental hospital eight months ago.

When I come across one of your journals I usually scan it from cover to cover, as I find it extremely helpful in the nursing care of my patients. The index of the July, 1960 issue, listing such topics as "Mental Diseases of Old Age," "Geriatric Nursing in the Home," "Life in an Old People's Home," "Nursing Home Care in Geriatrics" and "Social and Mental Health" seemed very interesting to me.

Would you be kind enough to put me on your mailing list for this valuable and interesting magazine. I am enclosing a cheque to cover the cost of a year's subscription and would appreciate receiving the July, 1960 issue as the first copy.

MARY MUTZ, Quebec

Dear Editor:

After reading Miss E. Mallory's article, "Whither We Are Tending," and attending the convention at Halifax, I have come to the conclusion that what the nursing profession needs most is a few realists. These may come to the fore if we study nursing service from the point of view of *service,* instead of education.

I would define nursing as a catalytic activity which helps to remove the *dis* from *disease.* Nursing is an *art.* It never was, and never will be a science. As with any other art the nurse must practise. Practice cannot be removed from the educational program for nurses — nor can it become the least important part of the program.

Nurse teachers need additional education as do any other teachers. Individual nurses will benefit from university experience and will graduate with a broader outlook on life, ready to give leadership. However, if we try to make the nursing course entirely a

university program with practice in the summer months only, we might as well resolve to call ourselves something other than nurses and give nursing care over to the nursing assistants.

If there is something amiss with nurses today, let us look at what we have. Are we supplying the needs of our patients? If not, what is lacking, and how can it be supplied? To my mind an important criterion of successful nursing care is patient satisfaction. Is the ill person being returned to a state of health in the most efficient and comfortable way possible?

The various educational systems across Canada all have merit but it is time to take the spotlight off *education* for a little while and consider where we are now. I feel that we will realize that we have "arrived." Nursing will grow and broaden but it will always be basically the same — the art of caring for the sick and injured.

JANE C. HALIBURTON, NOVA SCOTIA

Dear Editor:

Due to a change in my address I have missed my July *Journal*. I would very much appreciate receiving it if possible.

May I take this opportunity of expressing my sincere appreciation for your most interesting and informative magazine which I always look forward to receiving. It has certainly kept pace with the times.

GERTRUDE A. HIGGINS, Ontario

Dear Editor:

I am interested in knowing if reprints are available of the four articles on geriatrics which appeared in the July, 1960 issue of *The Canadian Nurse*.

ALTHEA W. BURNS, Vermont

¶*Reprints are not available for these articles but we have a number of copies of this issue still on hand.* Ed.

Dear Editor:

The series of articles on geriatric nursing in the July issue interested me greatly.

Our church group has undertaken to build a home for our elderly citizens and the experiences of others are very helpful in reaching decisions concerning the right and wrong ways of designing such accommodation. The article by Mrs. Brodsky was especially meaningful for this reason.

Since we are to have a meeting of our board very shortly, would it be possible for me to obtain extra copies to pass on to the members for reference purposes?

JANET MACCALLUM, Ontario

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 10

MONTREAL, OCTOBER 1960

Always Some Certain End

IT IS WITH A deep sense of humility that I accept the responsibility of the office of president of the Canadian Nurses' Association during the 1960-62 biennium. In accepting this responsibility I am grateful for the experience that I have been privileged to receive as a member of the Executive Committee of our association; for the encouragement and inspiration I have received from you, Madam President, and from many of our past presidents, one of whom we have honored today, and several of whom have participated in the discussions and decisions made at this 30th Biennial Meeting.

I am sure that many have experienced the feelings I have had recently, of soul-searching doubt and wonder as one faces the reality of a new and responsible position. However, in accepting the office of president, I have the assurance that I do not stand alone. You, Madam President, will give your support as a member of the Executive Committee, as will the three vice-presidents who take office with me today. Our general secretary and the fine staff at National Office carry much of the burden. The presidents and executive secretaries of our 10 provincial associations, and the four elected members of the Nursing Sisterhoods are members of the Executive Comittee also. Their knowledge, experience and judgment are invaluable in discussion, decision-making and formation of recommendations. Much of the work of our Association between biennial meetings is carried on by committees, and we call upon members in each province to serve. We are indeed fortunate to have the interested participation and active support of so many individuals.

At the close of this biennial meeting, we are conscious of the challenge of this new decade. Some may recall the words of Daisy Bridges in her keynote address at our 50th Anniversary, two years ago:

> I have recently read — and I am happy to have the opportunity of passing it on to you — that the future of Canada defies the imagination of man. You have a land of expanding industries and of vast untouched mineral resources. The whole country is pulsating with life; but the writer I am quoting continues: "Resources in themselves are not sufficient to bring prosperity; the

human element is still the dominating one. Confidence in the future rests on two major solid foundations. One, we have to admit, is wealth, the other is the character and quality of the people."

With the assurance of increased fees, our Association cannot boast of wealth but we will have a significantly larger budget than ever before with which to carry on our work. We have the largest membership in our history — seven times that of 30 years ago (which is within the professional life of many of our members) and nearly 50 per cent greater than that with which we started the decade just past. We have evidence of the character and quality of our members in the deliberations and decisions made this week, and in the organization and administration of the biennial meeting by our National Office staff, program committee, and last but not least, the cautious, stubborn and indomitable nurses of Nova Scotia.

There are many complexities and uncertainties on the political front, especially in international affairs, as we struggle to maintain peace and promote harmony among the nations of the world. There are complexities and uncertainties in the provision of health and welfare services. There are complexities and uncertainties within our own profession — but, as we have heard in the keynote address, the historian observes the gradual emergence of nursing as a profession with a fine tradition of service for the welfare of mankind. Sister Denise Lefebvre has also reminded us that "change in human thinking and acting takes a long time to be achieved."

It has become a tradition in our Association for the incoming president to give a watchword that will serve as an inspiration and guide in the forthcoming biennium. The seriousness of this responsibility was shared, I may tell you, by some members of our Association temporarily resident in the United States as students at Teachers College. Indeed, one was concerned to the point that she presented the president-elect with a copy of Bartlett's Familiar Quotations! There were many suggestions but the one finally chosen was found in a book on education in Great Britain. The author was discussing the qualities of the great teacher — imagination, perception, patience. The great teacher recognizes the potentialities of his students, and in his day to day work keeps before him the individual and ultimate objective he holds for each pupil. The author quoted a Latin phrase used by Matthew Arnold, an interested participant in education in Great Britain in the century just past.

Semper aliquid certi proponendum est
Always some certain end must be kept in view

I trust that as we continue the work of the Canadian Nurses' Association during this, the 1960-62 biennium, we will continue to seek inspiration in the watchword FAITH that has guided us during the past biennium and, in addition, that we will be guided by the new watchword: *Always some certain end must be kept in view.*

HELEN M. CARPENTER
President
Canadian Nurses' Association

The International Council of Nurses invites applications from nurses who have had some experience in the field of economic welfare, for a newly created full-time position at ICN Headquarters. She will undertake the promotion of an economic welfare program. Applicants must be members in good standing of their national nurses' association.

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* * *

The Catholic Hospital Association has published a collection of papers which were originally presented at a geriatric care institute. The publication, "The Administration of Long-Term Care Facilities" is available for $1.50, from the Publications Department, Catholic Hospital Association, 1438 South Grand Blvd., St. Louis 4, Mo.

Clinical Laboratory Procedures

E. M. Watson, M.D., F.R.C.P. (C)

This is a 1960 revision of the summary first published in 1949 then brought up-to-date in 1956.

Probably everyone associated with the activities of a large, modern general hospital must be impressed, if not confused, by the well-nigh innumerable tests that are performed on the patients. In this connection, the interest of the nursing staff in laboratory investigations should not be limited to mere formalities, such as the filling out of requisition forms, directing the technician to the proper patient and the collection and labelling of specimens. While these functions constitute important responsibilities of the nurse in relation to the proper conduct of laboratory tests, doubtless she will exert a more intelligent interest in her duties and have a better understanding of the patient if she possesses some knowledge of the procedures that are carried out. With a view to supplying relevant information in a condensed form, the following tables are presented.

Tests Identified by Proper Names

Frequently laboratory tests are ordered by using only a man's name, even although other terms might apply equally well. Technical and analytical procedures often are known best by the names of the men who discovered them or were associated with their development and popularization. Below are those most commonly encountered:

Addis count — a quantitative estimation of the cells and casts in urine sediment

Ascheim-Zondek — a test for pregnancy

Bence-Jones protein — a peculiar type of protein found in the urine of patients with myeloma and certain other diseases

Bodansky unit — the amount of phosphatase required to liberate 1 mg. of phosphorus

Coombs — a test used in pregnant women and newborn infants relative to Rh sensitization; also used in hemolytic anemias

Exton-Rose — a sugar tolerance test for detection of diabetes

Fantus — an estimation of chlorides in urine

Fishberg (concentration or dilution test) — Kidney function tests to evaluate the kidney's ability to concentrate or dilute urine

Frei — a skin test for a venereal disease, lymphopathia venereum

Friedman — a test for pregnancy

Hanger — cephalin-cholesterol flocculation test

Hinton — a test for syphilis

Kahn — a test for syphilis

Kepler or Kepler-Power — procedures for the diagnosis of Addison's disease

King-Armstrong unit — the amount of phosphatase required to liberate 1 mg. of phenol

Kline — a test for syphilis

Kolmer — a test for syphilis

Lange's Colloidal Gold — performed on the C.S.F. as an aid in diagnosis

Lee and White — a test of blood coagulation time, using venous blood

Maclagan — thymol turbidity and flocculation

Mosenthal — a two-hour specific gravity volume test for evaluating kidney function

Papanicolaou — a technique for the identification of cancer cells

Quick — a technique for estimating prothrombin; (refers to a man's name not speed of performance)

Paul-Bunnell — a serological test for infectious mononucleosis

Rose-Waller — a sheep cell agglutination test

Rowntree — P.S.P. test of kidney function

Rumpel-Leede — not a laboratory test but a method for determining capillary fragility by inflating a blood pressure cuff and counting the petechiae in a circumscribed area of skin.

Schilling — a special differential white cell count to determine the ratio of young to mature neutrophiles

Singer — latex fixation test used in connection with rheumatoid arthritis

Somogyi — often referred to in relation to serum amylase

Sulkowitch — a test for calcium in urine

Thorn — a test of adrenocortical function; effect of A.C.T.H. on circulating eosinophiles

Van den Bergh — a test of liver function

Wallace and Diamond — a method for estimating urobilinogen in urine

Wassermann — the original test for syphilis

Watson — urobilinogen in urine and feces

Westergren — a technique for performing the sedimentation test

Widal — a serological test for typhoid and paratyphoid fevers

Wintrobe — a special tube for determining red cell volume and sedimentation rate

Wohlgemuth — referred to in relation to serum amylase

Ziehl-Neelsen — a stain for acid-fast bacteria, usually for tubercle bacilli

Glossary of Abbreviations and Symbols

This is the era of the abbreviated form of expression. Often one is bewildered by the numerous combinations of letters referring to certain organizations or establishments. A growing list of abbreviations has entered into medical parlance. Abbreviations are frequently employed when requesting or referring to many laboratory procedures. Below are the most commonly used abbreviations and symbols with brief descriptions of their meanings.

Ac. — acid

A.C.T.H. — Adrenocorticotrophic hormone

A:G ratio — a figure obtained by dividing the value for the plasma or serum albumin by that for the globulin.

Alk. — Alkaline

A.-Z. test — Ascheim-Zondek, a test for pregnancy

A.F.B. — acid-fast bacillus; a characteristic staining quality of the tubercle bacillus.

Av. — average

B.M.R. — basal metabolic rate

B.S. — blood sugar

B.S.P. — bromsulphalein; a liver function test

B.T. — bleeding time

B.U.N. — blood urea nitrogen

C. — centigrade

Ca. — calcium

C.B.C. — complete blood count; usually implying hb., r.b.c., w.b.c., diff. and appearance of the red cells.

cc. — cubic centimeter

C.C.F. — cephalin cholesterol flocculation test

Cl. — Chlorine

CO_2C.P. — carbon dioxide combining power of blood plasma

Creat. — creatinine; a constituent of blood and urine

C.R.P. — C-reactive protein

C.S.F. — cerebrospinal fluid

C.V.I. — cell volume index

Diff. — differential; used with reference to a smear of blood or C.S.F. to determine the types and percentages of the white blood cells present.

ECG or EKG — electrocardiogram

EEG — electroencephalogram

Eos.—eosinophile; a variety of white blood cell

E.S.R. — erythrocyte sedimentation rate; sedimentation test

F. — Fahrenheit

F.B.S. — fasting blood sugar

F.S.H. — follicle stimulating hormone

g. or gm. — gram

G.A. — gastric analysis

G.C. — gonococcus; the causative organism of gonorrhea

g.i. — gastrointestinal

Hb. or Hgb. — hemoglobin

H. & E. — hematoxylin and eosin stain; used in the preparation of pathological material for examination.

Ht. — hematocrit

I.I. — icteric index; a chemical test on serum to reveal the degree of jaundice.

I.M. — intramuscular

I.V. — intravenous

K. — potassium

17-KS.—17-ketosteroids; a hormone assay on urine to study adrenal or other glandular disorders.

L. or l. — liter

L.E. — lupus erythematosus

Lymph. — lymphocyte; a variety of white blood cell

ml. — milliliter; 1/1000 part of a liter; approximately the same as cc. but a more exact expression of measurement.

M.C.H. — mean corpuscular hemoglobin

M.C.H.C. — mean corpuscular hemoglobin concentration

M.C.V. — mean corpuscular volume

mEq — milliequivalent

mEq./1 — milliequivalents per liter

Mg. or mgm. — milligram

Myelo. — myelocyte; the forerunner of the granular leukocytes

N. — nitrogen

Na. — Sodium

Neut. — neutrophiles; a variety of white blood cell

N.P.N. — non-protein nitrogen

O.T.—old tuberculin; a skin test for tuberculosis

p.a. — pernicious anemia

Pap. Stain—Papanicolaou stain for cancer cells

P.B.I. — protein-bound iodine; an estimation used in connection with thyroid function

pH. — a symbol used to express acidity and alkalinity

Pl. Ct. — blood platelet count

P.S.P. — phenolsulphonphathalein test; a method for assessing kidney function

R.A. — rheumatoid arthritis

r.b.c. — red blood cell count

Rh — Rhesus; the Rh factor

Retic. — reticulocyte

S.G.O.T. — Serum glutamic-oxalacetic transaminase

S.G.P.T. — serum glutamic-pyruvate transaminase

S.I. — saturation index; a test used in hematology

Sp. Gr. — specific gravity

T.P.I. — Treponema pallidum immobilization; a specific test of serum for syphilis

U.A. — urine analysis

Ur. Ac. — uric acid

w.b.c. — white blood cell count

W.R. — Wassermann reaction

Hematological Values

Determination	*Normal Values*	*Clinical Significance*
Hemoglobin	Adult males — 90 to 115% (av. 100) 14 to 18 gm. (av. 16) Adult females — 80 to 100% (av. 90) 12 to 16 gm. (av. 14) Infants — (1 day to 2 wk.) 100 to 160% (av. 120) 15 to 25 gm. (av. 20) Children — (6 mo. to 2 yr.) 65 to 100% (av. 80) 9 to 15 gm. (av. 12)	Decreased in the anemias. Increased in polycythemia and hemoconcentration (shock, burns, heart failure) Decreased in hemolytic disease of the newborn (erythroblastosis)
Red blood cells (erythrocytes)	Adult males — 5 to 6 millions per cu. mm. Adult females — 4.5 to 5.5 millions per cu. mm. Infants — about 7 millions per cu. mm. at birth; gradual drop to adult figure at 15th year.	Decreased in the anemias. Increased in polycythemia and hemoconcentration (shock, burns, heart failure)
Color index	0.85 to 1.0	Low in iron-deficiency and hemorrhagic anemias; high in pernicious anemia
Red cell volume (hematocrit — volume of packed red cells)	Males 42-50% Females 40-48%	Reduced in the anemias Increased in polycythemia
Cell volume index	0.85 to 1.15	Decreased in iron-deficiency anemia Increased in pernicious anemia
White blood cells (leukocytes)	5,000 to 10,000 per cu. mm.	Increased in many infectious and inflammatory conditions and in the leukemias Decreased in agranulocytosis, aplastic anemia and aleukemic leukemia
Differential white cell count	Neutrophiles 55-70% Mature forms 52-65% Young forms 3-5% Lymphocytes 20-30% (up to 50% in children) Monocytes 3-10% Eosinophiles 2-4% Basophiles 0.5-1% Myelocytes 0 Myeloblasts 0	Increased in many infections. Decreased in agranulocytosis Increased in lymphatic leukemia, infectious mononucleosis and whooping cough Increased in many allergic conditions Present in myelogenous leukemia
Eosinophiles (total)	100-400 per cu. mm.	Often high in allergies and Hodgkin's disease; diminished after ACTH with normally functioning adrenals
Fibrinogen	200-400 mg.% Fibrindex 10-60 seconds	Decreased or prolonged in severe liver disease and in a complication of pregnancy
Mean corpuscular hemoglobin	27-32 micromicrograms	Increased in macrocytic anemias (e.g. pernicious anemia); low in hypochromic anemias
Mean corpuscular volume	80-94 cu. microns	Same as above

Determination	*Normal Values*	*Clinical Significance*
Mean corpuscular hemoglobin concentration	33-38%	Increased in macrocytic anemias (e.g. pernicious anemia); low in hypochromic anemia
Peroxidase reaction	Lymphocytes have no granules; monocytes have a few and cells originating in the bone marrow (e.g. neutrophiles and myelocytes) have many	Useful in distinguishing acute lymphatic leukemia from acute myelogenous leukemia
Reticulocytes	0.5 to 1.5% of all red blood cells	Increased in p.a. following liver therapy (temporary) and in hemolytic anemia (persistent)
Red cell fragility (blood fragility test)	Hemolysis begins at 0.44 to 0.42% NaCl Hemolysis complete at 0.34 to 0.30% NaCl	Fragility increased in hemolytic jaundice; decreased in obstructive jaundice
Saturation index	0.9 to 1.1	Increased in macrocytic anemias (e.g. p.a.); low in hypochromic anemias
Sedimentation rate (Westergren method)	Men — 1 to 10 mm. in 1 hour Women — 1 to 15 mm. in 1 hour	Increased in infections and inflammatory conditions and in many organic diseases
Blood platelets (Thrombocytes)	200,000 to 400,000 per cu. mm.	Low in thrombocytopenic purpura and acute leukemia
Bleeding time	1 to 3 minutes	Prolonged when platelets reduced (as in thrombocytopenic purpura)
Coagulation (clotting) time	5 to 10 minutes (test tube method), 1 to 5 minutes (capillary tube method)	Prolonged in hemophilia; also after heparin administration
Clot retraction test	Complete and perfect in 24 hours	Delayed and imperfect in thrombocytopenic purpura (deficient platelets)
Prothrombin time	Prothrombin clotting time 14 to 17 seconds Prothrombin — 85 to 100%	Prothrombin clotting time increased and percentage decreased after dicumarol administration and in obstructive jaundice
Blood group (types)	O 45% of individuals A 40% of individuals B 10% of individuals AB 5% of individuals Rh positive 85% of individuals Rh negative 15% of individuals	Essential to determine before transfusions Important in pregnancy and certain conditions involving the newborn; also in persons receiving repeated transfusions

Blood, Plasma or Serum Chemistry Values

Determination	*Normal Values*	*Blood Specimen Required*	*Minimal quantity of blood required (cc. or ml.)*	*Note*	*Clinical Significance*
Amino Acid N	5-8mg.%	Oxalated	10		Increased in liver disease and eclampsia

Determination	*Normal Values*	*Blood Specimen Required*	*Minimal quantity of blood required (cc. or ml.)*	*Note*	*Clinical Significance*
Ammonia	10-20 μg. N.%	Oxalated	10	Test must be done immediately	Increased in severe liver disease and bleeding into g.i. tract, especially from esophageal varices
Amylase	12-17 Wohlgemuth units; 80-150 Somogyi units.	Clotted	10	Do not draw during or just following intravenous glucose or after administration of morphine	Increased in acute pancreatitis
Ascorbic Acid (vitamin C)	0.6-1.2 mg.%	Oxalated	5	Blood must be placed in a tube surrounded by ice and sent immediately to the laboratory	Low in scurvy
Bicarbonate	26-30 mEq./1	Heparinized or oxalated	5	Draw in special syringe without stasis from tourniquet	Reduced in acidosis Increased in alkalosis
Bilirubin (van den Bergh test)	0.1-0.5 mg.%	Clotted	10		Increased in jaundice; latent jaundice 0.5 to 2.0; clinical jaundice above 2.0
Bromide	0-1.5 mg.%	Clotted or oxalated	10		Important in the diagnosis of bromide poisoning
Calcium	9-11 mg.% 4.5 - 5.7 mEq./1	Clotted	10	Syringe and tube must be specially prepared to avoid error from calcium in tap water	Low in hypoparathyroidism and sprue (tetany); increased in hyperparathyroidism and some bone conditions
CO_2 Combining power	55 - 75 vol.%	Heparinized or oxalated	5		See bicarbonate above
Chlorides	96-105 mEq./1.	Clotted	5		Reduced by vomiting, starvation and after gastrointestinal surgery
Cholesterol Total Esters Free	140-250 mg.% 80-200 mg.% 50-60 mg.%	Clotted or oxalated	10	Total cholesterol and cholesterol esters done on same sample	Increased in hypothyroidism, diabetes and nephrosis
Copper	68-143 μg.%	Clotted	10		Decreased in hepatolenticular degeneration (Wilson's disease)
Creatinine	1-2 mg.%	Oxalated	5		Increased in severe nephritis

Determination	*Normal Values*	*Blood Specimen Required*	*Minimal quantity of blood required (cc. or ml.)*	*Note*	*Clinical Significance*
Glucose (fasting)	60-100 mg.% (true glucose) 80-120 mg.% (total reducing substances)	Oxalated	5	Up to 140 or 160 after meals.	Increased in diabetes mellitus; decreased in hyperinsulinism
Icteric index	4-6 units	Clotted	5		Increased in jaundice
Iodine (protein-bound)	5-10 micrograms %	Clotted	12	Strictly avoid any contact with iodine	Increased in hyperthyroidism
Lipids (total)	385 - 675 mg.%	Oxalated	10		Altered in various diseases
Lipase	0-2 units	Clotted	10		Increased in acute pancreatitis
Magnesium	1.8 - 3.6 mg.%	Clotted	10		Changed in various unrelated diseases
Non-protein Nitrogen	25-35 mg.%	Oxalated	5		Increased in nephritis, urinary and intestinal obstruction; decreased in pregnancy
pH (reaction)	7.35-7.45	Heparinized	5	Drawn in a special syringe without stasis.	Diminished in uncompensated acidosis; raised in uncompensated alkalosis
Phosphatase acid	1.5 Bodansky units 3.0 King-Armstrong units	Clotted	5		Increased in cancer of the prostate with metastases to bone
Phosphatase alkaline	Bodansky units Adults — 1.5-4. Children — 5-12. King-Armstrong units Adults 5-15 Children 10-20	Clotted	5		Increased in certain disorders of bone and in biliary obstruction
Phosphorus (inorganic)	Adults — 2-4 mg.% Children 4-6 mg.%	Clotted	5		Increased in severe nephritis and sometimes in rickets; decreased in conditions in which serum calcium is elevated.

Determination	*Normal Values*	*Blood Specimen Required*	*Minimal quantity of blood required (cc. or ml.)*	*Note*	*Clinical Significance*
Phospholipids	110-250 mg.%	Oxalated	5		Important in relation to disorders involving fat metabolism
Potassium	3.5 - 5.0 mEq./1	Clotted	10	Serum must be separated from the cells within 1 hour.	Increased in renal failure and severe Addison's disease; decreased in diabetic coma
Protein Total Albumin Globulin A:G ratio	 6.0-8.0 g. per 100 cc. 4.5-5.0 g. per 100 cc. 1.5-3.0 g. per 100 cc. 1.5 to 2.5:1	Oxalated or clotted	10		Decreased as a result of marked and prolonged albuminuria (nephrosis), liver disease and starvation, causing edema; increased in certain conditions associated with hyperproteinemia.
Sodium	136 - 145 mEq./1.	Clotted	5		Diminished by vomiting, gastrointestinal disorders, tube drainage (postoperative), diabetic coma, Addison's disease; increased after injudicious use of NaCl solutions in patients with impaired kidney function.
Sugar (glucose)	80-120 mg.%	Oxalated	5	See glucose above.	
Transaminase S.G.O.T.	10-40 units/ml.	Clotted	8		Increased in myocardial infarction (coronary) and infective hepatitis
S.G.P.T.	10-30 units/ml.	Clotted	8		Increased in acute hepatitis and relapsing cirrhosis of the liver
Urea	25-40 mg.%	Oxalated	8		Increased in nephritis; decreased in pregnancy
Urea Nitrogen	10-15 mg.%	Oxalated	8		Same as urea
Uric acid	3-5.5 mg.%	Clotted	10		Increased in acute gout, in nephritis and leukemia
Vitamin A	18-60 μg.	Clotted or oxalated	10		Subnormal due to deficient diet

Kidney Function Tests

Tests	*Principles*	*Normal Values*
Concentration test (Fishberg)	Based upon the specific gravity of 3 specimens of urine voided at hourly intervals in the a.m. after fluid restriction	Specific gravity of at least one specimen should be at 1.025 or higher

Tests	*Principles*	*Normal Values*
Dilution test (Fishberg)	Primarily a measure of the blood supply of the kidneys	First hour specimen about 400 cc. with specific gravity 1.001 to 1.003. Thereafter, less volume and higher sp. gr. with about 100 cc. at 1.012 to 1.016 at the 4th hour
Inulin clearance	Intravenously injected inulin is excreted; by glomerular filtration; there is no tubular reabsorption	The amount of inulin contained in 100 to 150 ml. of plasma excreted per minute
Mosenthal (2-hour specific gravity-volume test)	Based chiefly upon variations in specific gravity of 2-hour specimens during the day, and volume and sp. gr. of night urine	The difference between the highest and lowest sp. gr. not less than 9 points. The highest sp. gr. for the 2-hr. day specimens will be 1.018 or more. The night urine is 250 to 400 cc. with a sp. gr. of 1.018 or above
Phenolsulphonphthalein test	The dye is eliminated by glomerular filtration and tubular excretion	Both kidneys: 40 to 60% in 1st hour; 20 to 25% in 2nd hour (total 60 to 85%). Fractional method — 25% or more in 1st 15 minutes. Kidneys separately: first appears in 3 to 5 minutes after intravenous injection
Urea clearance	The excretory function of the kidney with special reference to urea is measured by a comparison of the concentration of this substance in the blood with that in the urine.	The average normal adult excretes the amount of urea contained in 60 to 95 cc. of blood per minute (average 75 cc.)

Urine Values

Determination	*Normal Values*	*Specimen Required*	*Note*	*Clinical Significance*
Amino acid Nitrogen	100-300 mg.	24 hr.		Increased in some liver and metabolic diseases
Calcium	Under 150 mg.	24 hr.	Patient must be on special diet	Increased in hyperparathyroidism
Chlorides	5 g. per liter	Random		Important in controlling saline administration
Creatine	Under 100 mg.	24 hr.	Preserve with toluol	Used in the study of muscle diseases
Creatinine	Males, 1.5 - 2 g. Females, 0.8 - 1.5 g.	24 hr.	Preserve with toluol	Normally excretion constant; altered in certain metabolic disorders
Diastase	16 - 30 units	Random	Urine must be fresh	Greatly increased in acute pancreatitis
Follicle - stimulating hormone (F.S.H.)	Before puberty, less than 6.5 mouse units per 24 hr.; after puberty, 6.5 - 52 mouse units per 24 hr.; after menopause, 96 - 600 mouse units per 24 hr.	24 hr.		Important in the investigation of endocrine disturbances

Determination	*Normal Values*	*Specimen Required*	*Note*	*Clinical Significance*
17-hydroxycorticoids	1-10 mg.	24 hr.	Keep urine cool	Important in the investigation of endocrine disturbances
5-hydroxyindolacetic acid (serotonin)	60-160 μg.	24 hr.	Patient must avoid eating bananas during the collection	Increased by carcinoid tumors
17-Ketosteroids	Under 8 years 0.2 mg. Adolescents 2-20 mg. Males 8-20 mg. Females 5-14 mg.	24 hr.		Important in the investigation of endocrine disturbances
11-oxy-ketosteroids	0.06-0.2 mg. per 24 hr., per sq.m. of body surface; adults, 0.1-0.4 mg. per 24 hr.	24 hr.		Important in the investigation of endocrine disturbances
Potassium	1.4-3.5 g.	24 hr.	Varies with the dietary intake	Useful in the study of renal and adrenal disorders and water and acid-base balances
Sodium	8-15 g. (as NaCl)	24 hr.	Varies with the salt intake	(The same as Potassium above)
Urobilinogen	Up to 1:20 dilution	Random or 24 hour	Preserve with sod. carb. under petroleum ether	Increased in liver disease and hemolytic jaundice

Liver Function Tests

Tests	*Principles*	*Normal Values*	*Note*
Bromsulphalein	Bromsulphalein after intravenous injection is excreted almost entirely by the liver	¾ hr. after the intravenous injection of 5 mg. per kg. not more than 5% of the dye remains in the plasma	Used in patients without jaundice
Cephalin-cholesterol flocculation test	This test depends upon the capacity of the blood serum in cases of parenchymal liver disease to flocculate a suspension of cephalin-cholesterol emulsion	0 to + + in 48 hours	Can be used in patients with jaundice
Galactose Tolerance	The liver is the only organ which can convert galactose to glycogen and store it	Normally not more than 3 gm. of galactose are excreted in the urine during a 5-hr. period following the ingestion of 40 gm. of galactose	Same as above
Thymol flocculation	The alteration in the plasma proteins in parenchymal liver disease causes precipitation of a solution of thymol	0 to + in 24 hours	Can be used in patients with jaundice

Tests	*Principles*	*Normal Values*	*Note*
Thymol turbidity	Same as above	0 to 4 units	More valuable in the diagnosis of acute than of chronic liver disease
Hippuric Acid synthesis	Based upon the capacity of the liver to conjugate glycine and benzoic acid into hippuric acid with elimination of this substance in the urine.	In the oral test the excretion of 3.0 to 3.5 gm. in the 4-hr. urine. In the intravenous test the excretion of 0.7 gm. in the 1-hr. urine	
Urobilinogen	Normally the liver re-excretes the urobilinogen absorbed from the bowel.	1 :20 dilution of the urine	

Investigations of Carbohydrate Metabolism

Tests	*Principles*	*Normal Values*
Standard 1-dose 2-hour Sugar Tolerance Test	A test of the ability of the body to store and utilize ingested dextrose	The fasting blood sugar is normal. After the ingestion of a specified amount of dextrose the blood sugar returns to normal within 2 hours. The maximum blood sugar should not exceed 180. No glycosuria
Two-dose 1 - hour (Exton-Rose tolerance test)	Based on the principle that the more sugar that is given to a normal person, the more is utilized	Blood sugar level of the 60 min. sample is less than, equal to, or does not exceed the 30 min. sample by more than 10 mg.%. No glycosuria
Intravenous Sugar Tolerance Test	Obviates the possibility of impaired absorption from the intestine	Blood sugar reaches the normal fasting level within 1 to 1½ hr.
Insulin Sensitivity Test	A test of the activity of insulin to promote the withdrawal of glucose from the bloodstream following ¼ unit of regular insulin per kilo. body weight	Blood sugar falls about 45 mg.% lower 1 hr. after ingestion of dextrose with insulin than with dextrose alone

Tests of the Cerebrospinal Fluid

Tests	*Normal Values*	*Clinical Significance*
Color and Appearance	Clear and colorless (like water) May be slightly blood tinged from needle trauma No clot	Cloudy, turbid or grossly purulent in meningitis. Bloody or yellow when hemorrhage involves central nervous system
Pressure	Adult-100 to 200 mm. water (patient lying down) 200 to 300 mm. water (patient sitting) Child-50 to 100 mm. water ((patient lying down)	Increased in meningitis, edema of the brain, hemorrhage, neurosyphilis Decreased in shock, dehydration and spinal canal block
Cell Count	1 to 5 per cu. mm. (lymphocytes)	Increased in the various types of meningitis, poliomyelitis, neurosyphilis and encephalitis Pus cells predominate in the acute bacterial processes Lymphocytes are found in tuberculous meningitis, poliomyelitis, and neurosyphilis

Tests	*Normal Values*	*Clinical Significance*
Colloidal Gold Test	0000000000	5554321000 Paretic type curve 0244310000 Luetic or tabetic type curve 0000245520 Meningitis type curve
Protein	15 to 45 mg. per 100 cc.	Increased in those conditions with an increased cell count (see above) Increased also in spinal cord tumor, caries of the spine and in infectious polyneuritis
Sugar	45 to 70 mg. per 100 cc.	Increased in diabetes, epidemic encephalitis, uremia and sometimes in brain tumor Decreased in acute meningitis, tuberculous meningitis and insulin shock Normal values generally found in neurosyphilis
Chlorides	Adult-720 to 750 mg. per 100 cc. Child-625 to 760 mg. per 100 cc.	Definitely low in tuberculous meningitis; high values may be found in uremia

Some Miscellaneous Procedures

Tests	*Normal Values*	*Clinical Significance*
Ascheim-Zondek and Friedman Tests	These tests are useful in differentiating cessation of menses due to disease condition and pregnancy; also in differentiating an enlargement of the uterus (fibroid) and pregnancy. Hydatiform mole and chorion-epithelioma give positive results. As a test for pregnancy it is about 98% accurate.	
Basal Metabolic Rate (B.M.R.)	15 to minus 10%	High in hyperthyroidism (toxic goitre, thyrotoxicosis) and leukemia Low in hypothyroidism (myxedema, cretinism)
Congo Red Test	Less than 40% of the congo red disappears 1 hr. after its intravenous injection	This is a test for amyloidosis and when this is present more than the normal amount of the dye disappears from the blood
C-reactive protein	Absent	Present in serum when there is acute inflammation or tissue necrosis, e.g. coronary thrombosis
Fecal fat	90-95% of the fat in the diet is absorbed, averaged over 3 consecutive 24-hour periods	Increased in steatorrhoea from any cause (malabsorption syndrome)
Gastric analysis Free HCl Total Acidity	Fasting — 5 to 20 degrees After test meal (without histamine) — 25 to 50 degrees Fasting — 15 to 45 degrees After test meal (without histamine) — 40 to 65 degrees	High when gastric or duodenal ulcer present. Low or absent with gastric carcinoma. Always absent in pernicious anemia after histamine
Latex fixation (the R.A. test)	Negative	A positive result is obtained in about 85% of patients with rheumatoid arthritis. Some other disorders (e.g. the collagen diseases) may give false positive reactions
Para-toluene sulphonic acid test (the L.E. test)	Negative	Significantly positive results (2+, 3+ and 4+) are produced by lupus erythematosus, liver disease, myelomatosis and occasionally by rheumatoid arthritis

Tests	*Normal Values*	*Clinical Significance*
Paul-Bunnell Test	Agglutination of sheep corpuscles in dilutions of serum up to 1 :16	This is a test for infectious mononucleosis in which agglutination occurs in high dilutions.
Radio-active Iodine (I^{131}) uptake	20 to 50% of administered dose is taken up by the thyroid gland in 24 hours	Increased uptake (more than 55%) in hyperthyroidism Decreased uptake (10 to 20%) in hypothyroidism
Sweat test	Sodium 10-80 mEq./L Chloride 4-60 mEq./L	Increased sodium and chloride in the sweat in fibrocystic disease of the pancreas (mucoviscidosis)
Urobilinogen in feces	Normally present	Increased in hemolytic jaundice Decreased or absent in obstructive jaundice
Xylose tolerance test	After ingestion of 25 g. of xylose, the blood level is 20-60 mg.% in 1 hr. and 15-76 mg.% in 2 hours. The urinary excretion is 4-8 g. in 5 hours	Xylose is absorbed from the intestine but not metabolized. Therefore, the test is useful in detecting malabsorption

Dr. Watson, until recently, was Professor of Pathological Chemistry, Senior Associate in Medicine, Faculty of Medicine, University of Western Ontario and Clinical Pathologist at the Victoria Hospital, London, Ontario.

A New Nursing Course at the University of Edinburgh, Scotland

The General Nursing Council for Scotland has approved an experimental scheme of nurse training proposed by the Nursing Studies Unit of the University of Edinburgh. The course, which begins this month, is planned to integrate the preparation for an Arts or Science degree, with that of the professional nurse. The M.A. or B.Sc. degree examinations will be completed at the end of three years, and the nursing course during the subsequent two years.

Final acceptance of the student will follow a four week period of planned observation and preliminary experience in a selected hospital, before the beginning of the course. Exemption from this condition may be granted if the candidate has previous experience of hospital work.

Students will be registered for an Arts or Science degree in the normal manner, the nature of the course having been decided by the Director of Nursing Studies, in conjunction with the Directors of Studies in the Faculties of Arts and Science.

During the first three years, both the theory and practice of nursing will be introduced, completion of the professional training occurring in the two years after graduation. A wide range of practical experience will be provided in the fields of general medicine and surgery, together with specialties, including psychiatric nursing, pediatrics, obstetrics and public health.

While students will be expected to become an integral part of the normal hospital student body, under the tuition of the established training school, additional supervision and assistance will be provided by the lecturing staff of the Nursing Studies Unit.

Conditions of entry will be the same as those for any prospective university student, demanding an attestation of fitness certificate. There will also be a preliminary interview.

Happiness depends upon how well you have made up your mind to be that way.

Behind the Scenes on Accreditation

Sister Denise Lefebvre, s.g.m., Ph.D.

This was a report of the Special Committee on the Pilot Project of Evaluation of Schools of Nursing in Canada, presented at the 30th Biennial Meeting of the Canadian Nurses' Association.

Introduction

Numerous social changes have emphasized the necessity of a review of educational objectives and programs. Our time is one of extraordinary scientific and technical revolution. Nursing follows in this march toward progress and is influenced most specifically by the new discoveries in medicine, psychology and sociology. Obviously, the field of nursing and the roles and functions of nurses have broadened. It follows that the institutions that undertake to prepare candidates for the nursing profession have a wider social responsibility. They must, consequently, make sure that their methods are adapted to the technical, scientific and social advances and the needs of our modern world.

The organized nursing profession has become, in the last few years, increasingly conscious of its responsibility in this field. Various studies and experiments, sponsored by the provincial or national nursing associations, have been carried out. The results of a two-year project representing a serious inquiry into Canadian nursing education will be presented in another article. That report is based on a survey which was made possible through the kind cooperation of schools of nursing. It is designed as a spotlight on our educational programs, but it also indicates the necessity and urgency for purposeful action toward the improvement of nursing education, in order to provide better nursing service to the people of Canada.

This report was prepared for the specific purpose of providing a summary of the activities of the Special Committee on the Pilot Project. This committee was formed in 1955 with one aim in view — to study ways and means of implementing a program of evaluation and accreditation for schools of nursing in Canada. According to its terms of reference, it acted in an advisory capacity only and at the request of the director of the Pilot Project.

The Background of the Special Committee

It was in 1956, at the biennial meeting in Winnipeg, that the Canadian Nurses' Association membership decided to undertake a research study on accreditation by approving the pilot project of evaluation of schools of nursing in Canada. This decision was based mainly on two facts:

1. A conviction that a program of accreditation would benefit the health and welfare of the people of Canada by providing more effective nursing service through improved preparation for that service;
2. an acceptance, by the profession, of the responsibility of evaluating the programs of education designed to prepare its members for the practice of nursing.

This was four years ago, but considerable preparation had preceded such action. Any change in the human



Sister Denise Lefebvre

Sister Lefebvre, who is the director of nursing at Marguerite d'Youville Institute, Montreal, was the chairman of the Special Committee whose work is described here.

way of thinking or acting requires time for achievement. In fact, the CNA general assembly had pronounced itself in favor of a program of accreditation 12 years before. In the intervening years, much thought, which was to bear fruit later, was given to the plan by the nursing education sections. The Canadian Nurses' Association appointed a provisional committee for the purpose of considering an accreditation program. The chairman presented a very convincing report after her visit to the National League for Nursing where she had studied their plan of accreditation and attended a workshop on this subject.

Various other attempts were made that served as motivation. Between 1946 and 1948, for example, the Canadian Conference of Catholic Schools of Nursing made an intensive study of evaluation methods. It carried out a field evaluation survey in 24 schools of nursing in eight provinces and the general results were published in *The Canadian Nurse,* April, 1950, p. 278. Such an undertaking certainly stimulated thinking as to the feasibility of establishing a national program of evaluation of schools. In an endeavor to keep the membership informed, a work conference on accreditation was presented in 1950, at the biennial convention in Vancouver. As a follow-up, a series of articles was published in *The Canadian Nurse.*

In the meantime, on numerous occasions, critical comments were heard, mostly from the public on the system of nursing education and especially on the product of our schools of nursing. A few nursing leaders presented their views on possible and necessary reforms. Experimental programs were launched. In the United States, an interim classification of schools and a program of improvement and of accreditation was carried on.

These developments, it is true, did not and could not appreciably change the basic organization of our programs. They did, nevertheless, disturb some of the long-accepted ideas and opinions on the methods used and the results obtained in nursing education. Questions had been raised in the minds of a number of Canadian nurses. This provided the incentive to search for improvement.

The Basic Work

In 1955, a working group was appointed. It was given the name of the "Task committee to study ways and means of implementing a program of evaluation and accreditation." Its first concern was to agree on fundamental principles and to present them for approval to the Committee on Nursing Education to whom it was responsible for the first two years, and later to the Executive Committee of the Canadian Nurses' Association.

Accreditation was defined as the official and public recognition of an institution after a careful analysis and evaluation of its program. It was agreed that accreditation should aim toward maintaining a high degree of professional education; that it should ascertain that the programs to achieve this were based on adequate norms; that it should be national in scope and voluntary in nature. It would thus be a means of stimulating schools toward constant improvement of promoting the cause of nursing education so that the nurse would be prepared in such a way that she would be capable of rendering the kind of professional service required by society.

In an accrediting program, it was felt that the main basis of judgment should be the school's objectives. It was recognized that these would vary in different institutions. If they were sound and the school was making an earnest, effective attempt to meet them, it seemed probable that accreditation would be granted. The committee felt strongly, along with other professional groups, that the philosophy of administration and of education should be reflected in the educational program of the school. Therefore, criteria for accreditation would have to be sufficiently flexible that the individuality of the school would be preserved. In order to maintain this individuality, the criteria or bases of judgment would have to be developed in cooperation with the schools of nursing themselves and should be under constant review.

With the above principles in mind and in order to obtain factual data on how these would be implemented in evaluating a school, professional associations already using various systems of accreditation were visited. A comprehensive report was prepared from

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the information obtained on objectives, methods, procedures and values.

Using this background material, the Committee recommended a plan of action and definite steps that might be taken. The plan of action suggested, as a first step, the initiation of a pilot project of evaluation of schools of nursing in Canada. About 20 to 25 volunteer hospital schools were to be chosen for a visit and complete evaluation of their program, according to definite criteria. On the basis of such a survey it was hoped to reach the following objectives:

1. To determine whether Canadian schools of nursing were ready for a program of accreditation;
2. To study the basis on which schools of nursing in Canada could be accredited;
3. To explore procedures;
4. To decide on the personnel and other means, including financial resources, needed to carry out a national program of accreditation.

It was suggested that, because of its many years of experience in accreditation, the assistance of the National League for Nursing should be sought.

A director was to be appointed who would be responsible for the entire survey. During her visits to schools, she would be accompanied by another member of the profession who would act as second visitor. In the French language schools, a senior bilingual visitor would be added to the survey team.

Further Preparation

The plan was accepted by the Canadian Nurses' Association. In immediate preparation for the project, all Canadian schools of nursing were notified about it by their provincial nurses' associations. It was most gratifying to find that 96 out of the 174 schools were willing to participate in the study. It was a responsibility of the Committee to select the 25 schools. This was done on the basis of size, form of control, classification of hospital, geographical location, language, so that the sampling would represent a cross section of diploma programs in nursing education in Canada. The actual choice was made in such a way that the distribution would balance fairly well regionally. There was at least one in each province. Out of the 25, there were 7 large schools (200 or more students), 11 medium (100-199 students), and 7 small (100 students or less). The institutions were not identified. No publicity was given in this regard by the CNA and coding was used in referring to the schools.

As the general information schedule used by the National League for Nursing was to be employed to gather school data before the visits, the Committee undertook to review the questionnaire and to make the necessary revisions so that it could be properly interpreted when used by Canadian schools.

While this process of selecting schools and reviewing the schedules was taking place, applications were received for a director for the Pilot Project. The Committee had the pleasure of greeting and welcoming Miss Helen K. Mussallem on her first visit to Montreal before she proceeded on to an orientation program offered to her by the National League for Nursing. The names of suitably qualified nurse educators to act as regional visitors and to assist the director, were submitted by provincial nurses' associations. This list and the supporting biographical data were studied by the Committee. The selection of 11 visitors was made on the basis of the candidate's experience in nursing education and nursing service.

The program called for a careful study of each school report by a Board of Review. Our Committee had the duty of suggesting names of members for this board. It was to be representative of various regions, and to include nurses who were actively engaged in nursing education, public health, nursing service and provincial nursing school visiting.

Collaboration with the Director

The framework seemed to be complete at this stage. The work of the Committee had consisted mainly, so far, in naming other people to accomplish the work of the project. After the appointment of the director, we were entrusted with the very agreeable duty of observing the progress of the study. The director periodically reported to the Committee on the survey visits; her activities in the interpreta-

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tion of the project to various groups; the work of the regional visitors, of the liaison committee and of the Board of Review. She submitted an outline of her final report of the project and, finally, the completed draft with her recommendations. The latter were endorsed by the Committee.

At every step forward the members of our Committee expressed their satisfaction. Now, we rejoice at the successful completion of a challenging and exacting piece of work. The results were made possible through the competence, devotion and courage of the director. She was helped in part of her work by the efforts of an admirable team of regional visitors and by the cooperation of our National Office staff.

The Special Committee on the Pilot Project was dissolved recently. Its functions had been fulfilled; its report had been submitted to the Executive Committee of the Canadian Nurses' Association; its services were no longer required. I am sure that I express the views of its members when I say, that as individual nurses, we could not, after this experience, remain indifferent to the impact of the Pilot Project report on the nursing profession and to the answer that nurses will give to its thought-provoking questions.

Conclusion

In concluding this report, I take great pleasure in expressing my sincere gratitude to the members of the Special Committee, to Miss Mussallem and to all those who, directly or indirectly, have contributed.

Our president, Miss Alice Girard, in the foreword to Miss Mussallem's report, expresses her views in the following terms:

> A profession which seeks by its service to earn the confidence and approval of the society it serves, assumes also the responsibility of maintaining that service at the highest possible levels of competence and effectiveness. Such standards are difficult to achieve and maintain, and they require from the profession the humility and integrity that permit and demand constant self-evaluation.

We should go back from this convention with a desire to change our methods if necessary, and a conviction that we have, each one of us, a personal responsibility to help establish or to maintain a sound system of nursing education. We do not like dictatorship, but we sometimes invite it by our attitude. How often do we wait until we are *told* what to do before we go ahead in our educational programs? This is our opportunity! If we would strive toward high ideals, let us not be too easily satisfied with our achievements, but rather let us be eager to work at the betterment of the profession.

In the Good Old Days

(The Canadian Nurse — October, 1920*)*

A number of women justices of the peace have recently been appointed in England, and now they have been put on juries. One woman thought it was a good thing that women were at last permitted to serve on juries, as they understood better than men the ways of their sex.

* * *

McGill University School for Graduate Nurses announced the start of its program with the opening of a one-year course for graduate nurses.

* * *

Tuberculosis figures for Canada indicated that there were over 10,000 deaths annually from this disease. It was estimated that there were at least 100,000 cases throughout the country as a whole.

* * *

Dalhousie University recorded the graduation of its first class in public health nursing.

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Survey for a transcontinental air line was completed with Camp Borden as the chief air station for Canada. This marked the beginning of TCA.

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— *Guy's Hospital Gazette,* April, 1960



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Spotlight on Nursing Education

Helen K. Mussallem, M.A.

The Pilot Project for Evaluation of Schools of Nursing has been completed. The recommendations arising out of it have far-reaching implications for nursing.

General meetings of the Canadian Nurses' Association are exciting events. At these times we are able to pause and acknowledge the accomplishments of the past, reflect on the problems that we have met, and chart our course toward new goals. This is, then, a review of the past, an evaluation of the present and the formulation of plans for the future.

At this General Meeting of 1960, we are to assess the Pilot Project for Evaluation of Schools of Nursing, review what has been done, evaluate what is being prepared and plan for what may follow. I find it difficult to believe that the hour has finally arrived, when I may, on behalf of all those who participated, make the statement that the Pilot Project has been completed and that the recommendations await your consideration. It is the end of the flight for the Pilot Project for Evaluation of Schools of Nursing. Only you can make the decision as to whether or not we shall be airborne again, and what the flight orders will be.



(Kern of Artona)

Helen Mussallem

Sister Lefebvre has presented an excellent account of the background leading up to the project, its immediate preparation and the work of the committees and other personnel. It is my privilege to present the highlights of the Report of the Pilot Project and the recommendations made as a result of this study.

Format of the Report

> The Pilot Project for Evaluation of Schools of Nursing was an examination of the status of schools of nursing in Canada to determine their readiness for a program of national voluntary accreditation.

The report contains the observations, findings, conclusions and recommendations arising out of this purpose. It is a critical analysis of the educational programs in schools of nursing to the end that better nursing service may be provided. In the foreword to the report our president, Miss Girard, stated that

> by its very criticism, it underlines the capacity of nurses to engage in the self-assessment that is necessary if we are to live up to our ideals.

The first chapters deal with the background of the Project, its administration and organization (which includes the selection and functions of committees and other personnel), the methods used in all phases, and the data obtained from the schools surveyed. The final chapters contain the summary, conclusion and recommendations. Additional information relating to the Project is contained in the appendices. This includes such items as the questionnaire used, a list of supplementary information provided

Miss Mussallem, the director of the Pilot Project, presented this commentary on her final Report at the biennial meeting.



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by the school at the time of the survey, a sampling of verbatim opinions expressed by people about the Project and accreditation in general and the present methods used in the survey of schools.

Project Procedures and Phases

The general procedures used throughout the survey and described in the Report, were those that had been developed by the National League for Nursing Accrediting Service. This service has had over 20 years of experience in accrediting schools of nursing. Without the assistance provided so generously, this project could not have been completed in the allotted time. The NLN also gave the director an orientation to its procedures of accreditation and permitted use of all its materials and criteria. These criteria were modified for use in the Canadian schools of nursing and were considered by the Board of Review to be suitably applicable in every way to the Canadian patterns of nursing education.

The Project as planned and described, falls into three phases. The initial phase included visits to all participating schools and involved addressing meetings of nurses and allied professional groups. Conferences were held with executive directors of these allied services, deputy ministers of health and other interested groups.

The major portion of the intermediate phase was devoted to one-week surveys of the 25 schools. A detailed account of the procedures and methods used during this period, as well as a description of a typical survey are recorded. The one-week visit was used for a comprehensive survey of the educational program of the school. A massive amount of material that required at least one full day to study resulted on each occasion. Visits were made to all areas of the school, to hospital wards where students received their clinical experience and to an affiliating agency. Conferences were held with all of the individuals and groups who were directly or indirectly connected with the educational program. The visitors' main responsibility during the week was to write a factual report on the school's program which would be submitted to the Board of Review for evaluation.

The visitors did not evaluate the school or the survey report. They were essentially a fact-finding team. The evaluation was made by the Board of Review. The visit was not planned as an inspectional tour but as an educational experience for all who were involved. The extensive nature of the visit may be realized when it is estimated that each visitor was involved for approximately 65 hours of the week with the survey and the writing of the report. When the survey report was completed, it was read to the staff of the school to familiarize them with its contents, to clarify any misunderstandings, and to obtain additional information. Once the report had been read and any corrections had been made, it was typed in CNA National Office and returned to the school for further reading and correction. By using this procedure, there was assurance that the report was accurate. It was then studied by the Board of Review and later used as the basis of the data in the study.

Throughout the Project, the staffs of the schools, the nursing members of affiliating agencies and nursing students were asked to comment in writing on the entire evaluation procedure and to mail their comments unsigned to National Office. A sampling of these remarks is contained in the Report.

The final phase of the survey was a detailed evaluation by the Board of Review of each survey report.

The Board of Review

Using the criteria of the Project, the Board of Review evaluated each school — identified only by a code number — on the basis of its report and additional clarifying information provided verbally by the Director. Following the evaluation of a program, the Board listed, for the school concerned, a summary of the factors in its program that indicated strength as well as the areas that required study. Copies of the report which had been checked for accuracy by the school prior to the meeting of the Board, were then returned to the school with the Board's evaluation.

In each instance the Board also voted, on the basis of the over-all quality of the program, on the eligibility of the school for full accredita-



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tion, if such a program had been in effect. In the opinion of the Board of Review, four of the 25 educational programs had the over-all quality needed for the award of accreditation. Although only four of the schools surveyed merited this standing, there was wide variation in the quality of the programs of the remaining 21.

Following their evaluation of the schools, the Board members were asked if they considered the criteria applicable to diploma schools of nursing in Canada. The consensus of the group was, that generally speaking, these criteria were applicable.

Facts and Figures

The data obtained from the schools are discussed and tabulated in chapter five of the Report. This section has been divided into the 10 areas used in the survey of the school. The report of the Pilot Project is a *factual* report. No mention has been made of the interest, enthusiasm and eagerness of the school faculties and hospital authorities. At all times, the surveyors worked in a very favorable climate. No effort was spared to make all the information that was required available. Every assistance was provided to facilitate a heavy and demanding schedule. This was all the more appreciated because, in each instance, the members of the school staff were carrying on with their own heavy work load during the survey week.

It is difficult to summarize this chapter. There are 34 tables as well as a discussion of related information. I will point out only a very few of the areas. I trust that you will explore the others by yourself. In discussing these, I wish to acknowledge the great contribution made by the individual members of the schools of nursing working in their own setting, and often under difficult circumstances. One always gained a feeling of deep respect and admiration for the work of each nurse in her own field of endeavor. After every day-long curriculum conference in the schools, during which individual instructors described their contribution to the total program, I was left with a feeling of great humility. But there are many things that we can all do much better and it is to these areas that I refer specifically.

One of the most critical situations encountered in the survey was the lack of post-basic preparation of the full-time instructors. It is recognized that formal preparation in a university is not a guarantee of competency in teaching. Yet it cannot be denied that trial and error methods of teaching are both hazardous and extravagant. It is of interest to note that the figures obtained from 171 schools of nursing during a recent survey on the preparation of instructors by the national Committee on Nursing Education are almost identical with those obtained from the survey of the 25 selected schools. There is a variation of about one-tenth per cent.

Of the full-time instructors, the survey revealed that 30.9 per cent had no preparation for teaching; 43.8 per cent had a certificate or diploma obtained following one year of study at a university: 21.5 per cent had a baccalaureate degree and 3.8 per cent had a Master's degree.

Of the many areas of concern in relation to student personnel services, one in particular might be mentioned. The results showed that in the majority of schools the student was regarded as a member of the working staff force and her hours were regulated accordingly. In most cases students were engaged in the clinical setting for four to eight hours more per week than graduate nurses. To me this situation revealed a need for clarification of the role of the student as a learner in an educational program which includes experience in the clinical setting.

In the section devoted to curriculum you will note the areas of strength and the areas requiring study. Nurses directly involved with school of nursing curricula will want to study this section in detail. In most cases the clinical setting for the educational program was not surveyed as comprehensively as the visitors would have preferred. However, efforts were made to determine whether the quality and quantity of patient care provided by the nursing service staff ensured a suitable environment for learning.

One table of particular interest is the *Percentage and Time Spent in the Clinical Setting by Graduates, Students and Non-Professional Personnel for a*

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Archambault, R.: Canad. M.A.J. 1:28, 1959.

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24-hour Period During the Survey. Even a casual glance at this table will reveal the heavy nursing load carried by students, particularly on evening and night duty. Although not indicated in this table, those situations where students carried 90 to 100 per cent of the work load were also those in which the supervision was extremely limited. In several cases students were carrying responsibility for patient care and ward administration far beyond the level of their preparation.

Chapter Six contains a summary of data under two headings — the strengths observed in the majority of schools and the areas requiring study and improvement.

The Recommendations

The summary of these data and the conclusions reached are commended to you for study. On the basis of the findings of this Pilot Project, the main purpose of which was "to determine if Canadian schools of nursing are ready for a program of accreditation, and if it is feasible at this time to initiate such a program" the following recommendations are made:

Recommendation 1

That a re-examination and study of the whole field of nursing education be undertaken.

Recommendation 2

That a school improvement program be initiated to assist schools in upgrading their educational programs.

Recommendation 3

That a program be established for evaluating the quality of nursing service in the areas where students in schools of nursing receive their clinical experience.

Recommendation 4

That a program of accreditation for schools of nursing be developed by the Canadian Nurses' Association.

Conclusion

As we review these recommendations it is of interest to note what is being said by those in the field of general education. Dr. George Flower, Toronto has said:

> This then is the state of education today: a mixture of certainty and uncertainty. Certainty, on the one hand that education is supremely important, is the servant of all our purposes; uncertainty, on the other, as to purpose and programs and procedures and ways and means. As a people we are willing to move — we *are* moving — educationally, but we do not move together. The action of one often offsets the action of another, and none of us seems entirely satisfied with the results. The big problem is, how can all this interest and drive and concern and conviction be harnessed, be coordinated, be channelled, the better to serve us as individuals and as a nation?

Dr. Flower's words seem to be an accurate and admirably phrased presentation of the challenge facing nursing education in Canada today.

To conclude, may I quote from the preface to the Report of the Pilot Project.

> Participation in this project was a rare privilege and a unique opportunity to become involved in an exciting professional journey. At the beginning of such a journey, it is difficult to predict the adventures that lie in store before the goal is reached but there were many. Because of the nature of the technical report these experiences are not recorded here. Only factual information is presented. Some day the other part of the story may be written. If as a result of this project, the way ahead in nursing is more clearly visible then the efforts of the many who participated will be well rewarded.

Morally considered, laughter is next to the Ten Commandments and according to medical reports, laughter stimulates the vasomotor centers, and the spasmodic contraction of the blood vessels causing the blood to flow quickly. Laughter, too, accelerates the respiration and gives warmth and glow to the whole system. It brightens the eye, increases the perspiration, expands the chest, forces the air from the least-used cells and tends to restore the exquisite poise and balance that we call health. All this — and Heaven too — laughter may also serve to restore one's hearing. It is actually one of the best types of physical exercise; and it is available to many to whom no other exercise is practicable.

— *The Volta Review*, August, 1960

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Text: *St. Matthew 20: 26-28.*

. . . whosoever will be great among you let him be your minister; And whosoever will be chief among you, let him be your servant: Even as the Son of man came not to be ministered unto, but to minister, and to give His life a ransom for many.

The Christian religion exalts service to our fellow human beings as one of the greatest of all virtues. It sets before us the example of the wonderful Man of Nazareth, who in the days of His flesh went about doing good and healing all manner of sickness and disease among the people. It teaches that the best in life eludes those who live only for themselves. Contentment can come only to those who give of their talent and their energy for the good of others. The life of service has its headaches and its heartaches, its disciplines and its sacrifices, its discouragements and its frustrations; but it brings rewards and satisfactions which more than compensate for all its drawbacks.

No group of human beings is more completely dedicated to the ideal of service to humanity than are the members of the nursing profession. They richly deserve the place of esteem and respect which they hold in our society. Caring for the sick is more than a job, it is a ministry; a ministry of patience and cheerfulness and gentleness. It requires skillful hands, and level heads, and loving hearts. There are things to be done which are anything but pleasant. Pain, anxiety, tragedy, and death are the nurse's daily companions; and in the midst of it all, she brings comfort and reassurance.

1960 is the fiftieth anniversary of the death of Florence Nightingale. She died at the age of 90 on August 13, 1910. More important, this is the one hundredth anniversary of the opening of her nurses' training school at St. Thomas's Hospital, London: perhaps the most significant of all landmarks in the development of modern nursing. To recall the name of Florence Nightingale is to be reminded that yours is a great tradition; a tradition of determination and courage, of battling against prejudice and inefficiency, of holding on to a dream until that dream becomes a reality. Miss Nightingale's first struggle was a family affair. She belonged to the British aristocracy, and in their eyes nursing was a degrading task fit only for the uncultured and the disreputable. Her next battle was a much sterner one. In the Crimea she had to contend not only with the deplorable conditions in which the sick and wounded lived and died, but also with the antagonism of the high command. The fact that she persevered and triumphed in the face of such seemingly insurmountable obstacles has placed the whole world in her debt. Well does she deserve to be remembered with respect and gratitude as the founder of modern nursing.

There are others who share with Miss Nightingale the honor of having made the nursing profession what it has become. We remember Elizabeth Fry, of prison reform fame. She was 40 years old when Florence Nightingale was born. With her simple Quaker faith and her amazing energy she had stirred the nation's conscience to a sense of shame because of conditions behind the cold, forbidding walls of the jails. Her compassion for the prisoners spilled over to include the sick, and among her acts of charity was the founding of an institution of nursing sisters in London. Elizabeth Fry exerted a formative influence upon Miss Nightingale, and her name too deserves to live in grateful memory.

Another honored name is that of Edith Louisa Cavell, the British nurse who went to Brussels in August of 1915, and there nursed the victims of war regardless of the uniform they wore. Arrested and imprisoned by the Germans, she admitted to sheltering and helping to convey to safety some 200 wounded English, French, and Belgian soldiers. Sentenced to death, she faced the firing squad with a dignity which moved the world. To the British chaplain who ministered

Rev. Mr. Hilchey is rector of St. Paul's Church, Halifax, N.S.



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to her in her last moments, she made a comment which has become as famous as almost any in English history, "Patriotism is not enough." Greater than patriotism is that humanitarian sentiment so pointedly illustrated in our Lord's parable of the good Samaritan. The ministry of mercy and of healing admits no boundaries of nationality or race or creed.

Long before the time of Elizabeth Fry, Florence Nightingale and Edith Cavell, women of compassionate heart and fearless spirit were ministering to the sick. Many of them were ladies of rank and wealth who made great sacrifices on behalf of the poor and the neglected. One of those to whom Christian history pays glowing tribute is Fabiola, a Roman lady of the bluest blood who lived 1600 years ago. Her two marriages ended tragically and brought her as a humble penitent to the door of the Church. Having received absolution and been admitted to Communion, she devoted herself and her fortune to the care of the sick for whom nothing was being done. Somewhere about the year 380 A.D. she founded in Rome a hospital with a convalescent home attached. Not content to wait for the sick to come to her hospital, she went out into the slums to collect and care for them. We may say of her that she was the ancient forerunner of the modern nurse.

This then, is the tradition in which you stand; a tradition graced by countless women who have ministered, often in very trying circumstances, to the sick and diseased. Sometimes, as you move about the well equipped hospital in which you serve, think of the past and marvel at the faith and the courage of those who pioneered your profession. Then whisper a prayer that something of their spirit may be evidenced in you.

These great women about whom we have been thinking were all convinced and practising Christians. No one can study the history of medicine without recognizing the tremendous impetus which the Christian faith has given to the ministry of healing. Long ago Jesus placed strong hands in healing and blessing upon sick and suffering people. When He commissioned His followers to go into all the world, He bade them not only preach the Gospel, but also heal the sick. His example and His instructions have been the inspiration of those in every generation since His time who have sincerely tried to live the Christian life. They have sought to imitate His compassion for the diseased, the crippled, the blind and the deaf. A great man once put it forcibly when he remarked that if Christ came to London tonight, He would not go to its largest church, but to its largest hospital.

We all welcome the advances that have been made in medical knowledge and technique during the past century. Private charity has been replaced by state-provided hospitals. The haphazard methods of days gone by have given way to the scientific approach which is so typical of the twentieth century. But let us not forget that medicine is more than science. Medicine must have a heart, a heart of compassion which looks upon the sick not as patients but as persons, not as "cases" but as individuals. We welcome the new partnership which has been developing lately between doctors and clergy, between those who minister God's healing gifts through surgery and medication and those who minister them through prayer and sacrament. This kind of combination will ensure that scientific medicine does not lose the human touch which is so necessary in dealing with people. Never let the heart go out of your nursing. Keep your compassion fresh.

Those who give themselves to the ministry of healing give themselves to the service of God. It it God's work we do and Christ's ministry we share, when we unite skilled hands, level heads and warm hearts in doing for others what they cannot do for themselves.

May God bless you in your ministry to the sick.

Wisdom is knowing what to do next, skill is knowing how to do it, and virtue is doing it.
— David Starr Jordan

Everyone is a moon, and has a dark side which he never shows to anybody.
— Mark Twain



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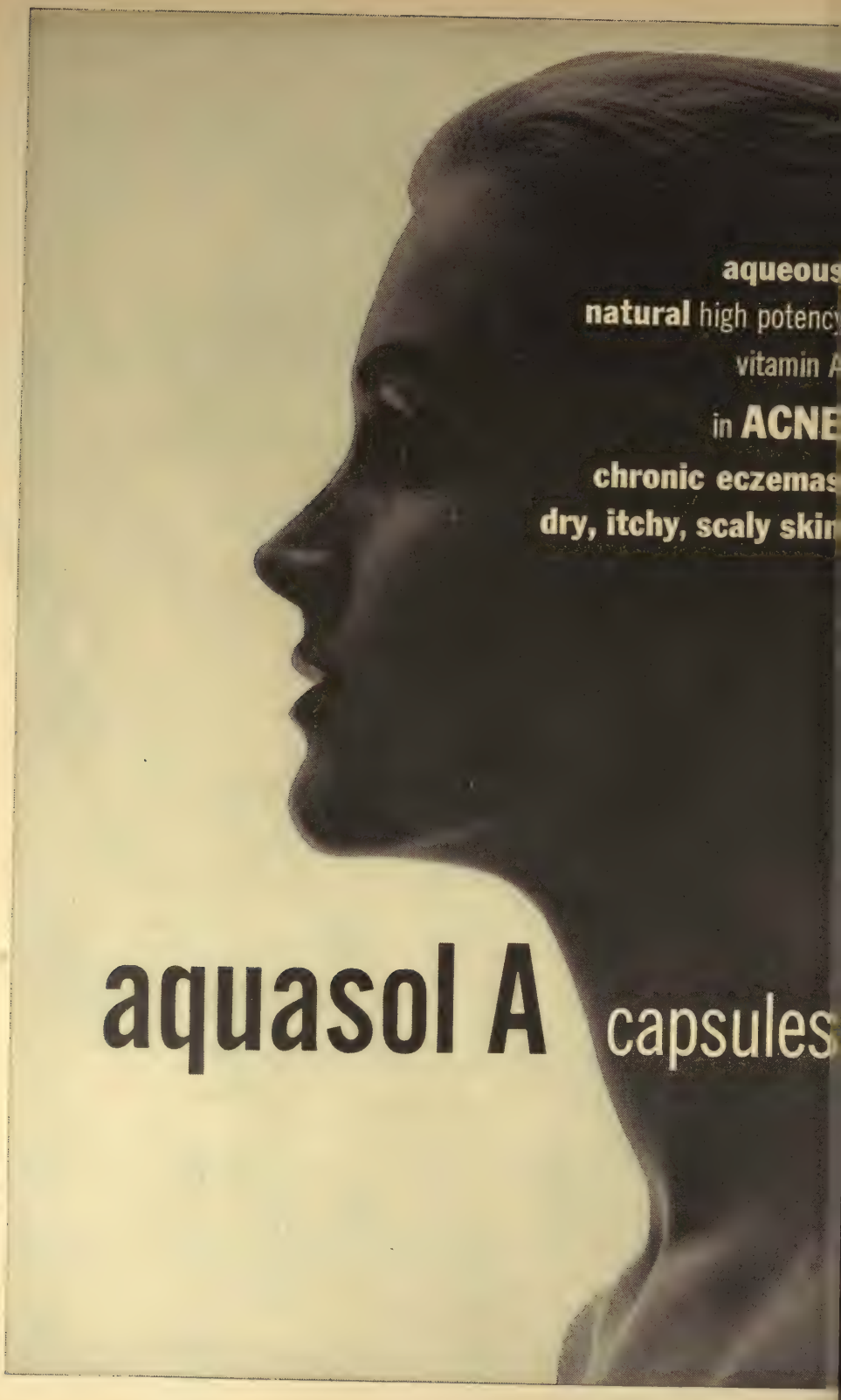
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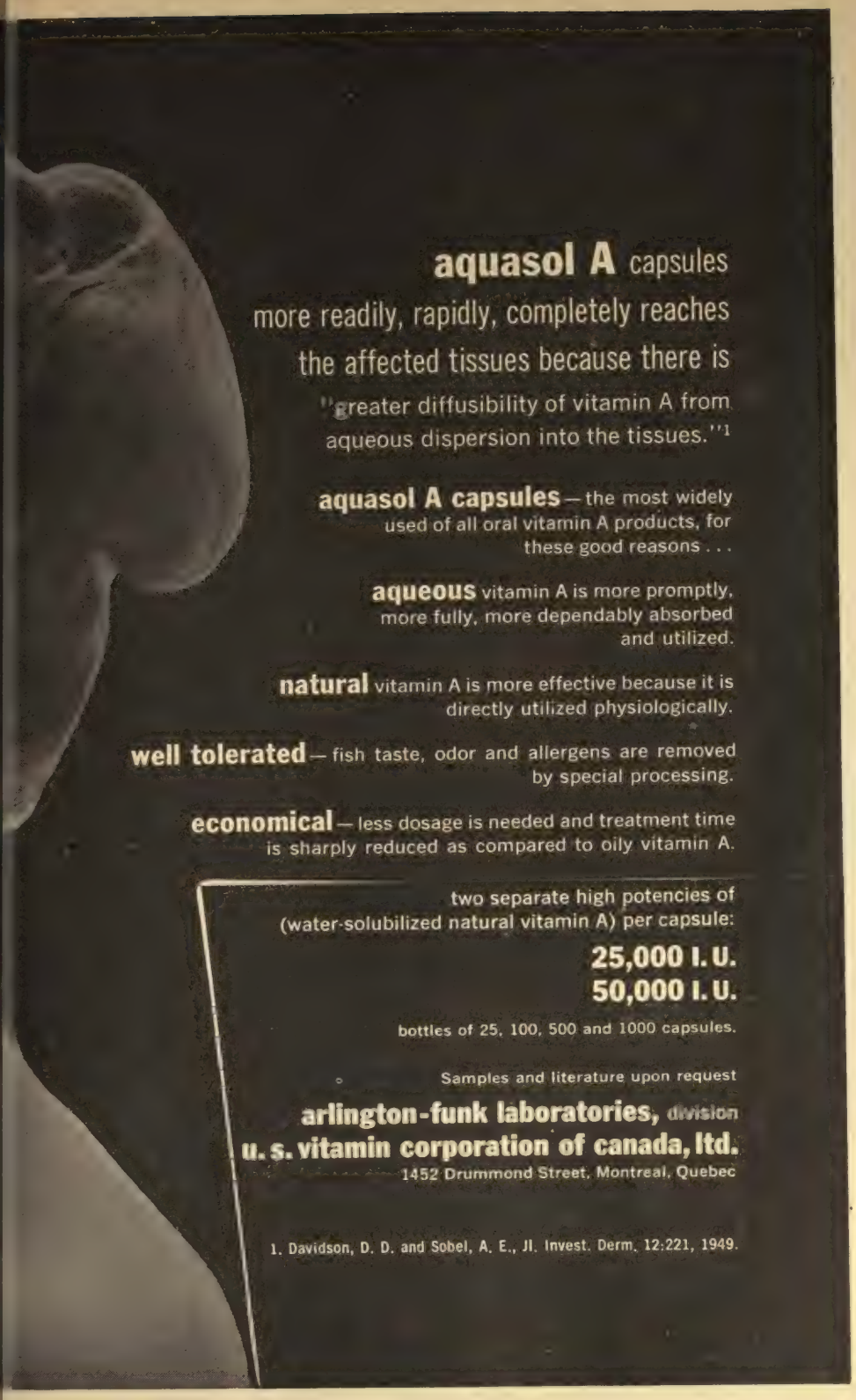
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1. Davidson, D. D. and Sobel, A. E., Jl. Invest. Derm. 12:221, 1949.

MEET THE EXECUTIVE

During this biennium many of the affairs of the Canadian Nurses' Association will be a responsibility of certain members of the Executive Committee recently elected or re-elected at the 1960 general meeting. We are pleased to have this opportunity to introduce these new officers of our national association.

E. A. Electa MacLennan is already a very familiar figure on the Canadian nursing scene. Director of the School of Nursing connected with Dalhousie University, Halifax, she will be remembered by many nurses for her work at the McGill School for Graduate Nurses as assistant director and assistant professor in public health nursing. Still others will recall her extensive association with the Victorian Order of Nurses, first as a staff nurse and later as a National Office supervisor. She holds her Master of Arts degree from Columbia University and, in 1956, she was made a Fellow of the American Public Health Association.



(Wright Studios)

E. A. Electa MacLennan

Miss MacLennan's interest in nursing affairs at the national level is long-standing and well-proven. During the 1944-46 biennium she took charge of publicity work for the CNA as one of her responsibilities as assistant secretary in our National Office. During this past biennium she chaired the Committee on Legislation and Bylaws while fulfilling her duties as second vice-president. Now we welcome her as first vice-president and chairman of the Committee on Finance, knowing that we will continue to benefit from her enthusiastic and energic efforts on our behalf.

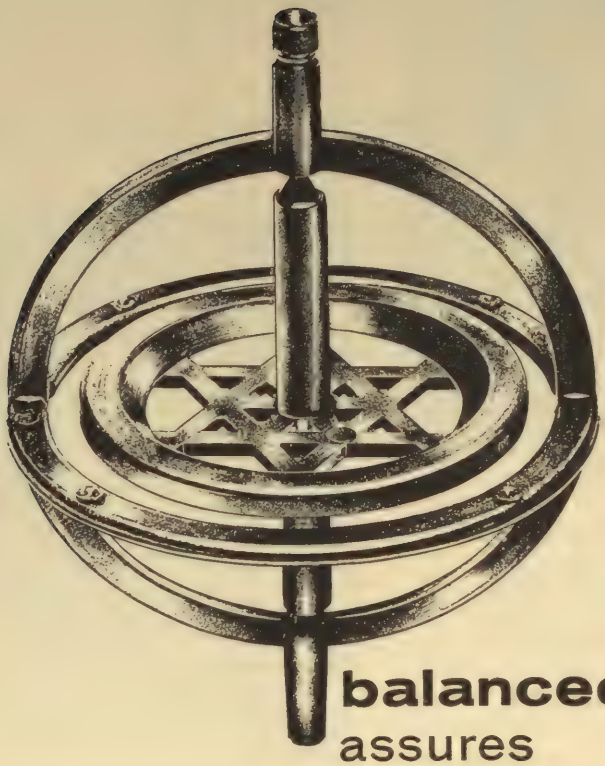


(Esquire Photo, Saskatoon)

Hazel B. Keeler

Hazel B. Keeler, second vice-president, has been reappointed as chairman of the Committee on Nursing Education. Director of the School of Nursing, University of Saskatchewan, her interests have led her far into the field of nursing education and to many localities ranging from British Columbia to Ontario and south of the border to the University of Buffalo where, for a two-year period, she was associate professor of nursing education. Many Canadian nurses are probably familiar with the Saskatchewan centralized lecture program for nursing students that became effective early in 1953. Miss Keeler has been very actively associated with this program as an over-all planner, coordinator and adviser to the participating schools of nursing. It can be readily seen that she is well-qualified to direct the activities of her particular committee.

Katherine E. MacLaggan, director of the School of Nursing, University of New Brunswick, and our new third vice-president is a capable addition to the Executive Committee. Training as a teacher in the field of general education preceded preparation for nursing. A Bachelor of Nursing degree from



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KATHERINE MACLAGGAN

McGill School for Graduate Nurses in 1952 was followed by a Master of Arts from Teachers College, Columbia University in 1957 with a major administration in nursing education. Her efforts on behalf of nursing in the province of New Brunswick have been outstanding. It was no whim of fate that led to her appointment as chairman of the committee charged with implementing the recommendations of the Russell Report which developed out of the survey of nursing in that province conducted by Miss E. Kathleen Russell.



(Chevrons Studio)

MARY RICHMOND

As a chairman of the Committee on Nursing Service, **Mary L. Richmond** has accumulated considerable experience related to this area of nursing and its attendant problems. She has been the director of nursing, Royal Jubilee Hospital, Victoria since 1956. In recent months she was associated with the Pilot Project on evaluation of schools of nursing as a member of the Board of Review and as a regional visitor in Alberta. She will provide capable and sound leadership.



(Newton)

ETHEL GORDON

The chairmanship of the Committee on Public Relations has been returned to the very efficient direction of **Ethel M. Gordon.** During the past biennium under her guidance the Committee prepared the "CNA Platform" that was officially accepted by the convention delegates. As chief supervisor of nursing counsellors, Civil Service Health Division, Department of National Health and Welfare, Miss Gordon has a very busy professional life. Her background of public health experience with the Victorian Order of Nurses for Canada and with the Central Tuberculosis Clinic in Winnipeg has given her much understanding of this field. Her interest in professional affairs has been active and fruitful. The development of the Industrial Nurses' Committee of the Registered Nurses' Association of Ontario came about partly through her efforts.

We know that the report of the Committee on Public Relations in 1962 will show the same evidence of dynamic action that it did in 1960.

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References: (1) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (2) Editorial Comments: *Canad. M. A. J.* 82:537, 1960. (3) Brownrigg, G. M.: *Canad. M. A. J.* 73:787, 1955. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844, 1957. (5) Royer, A., in Welch, H., & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

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SISTER MADELEINE OF JESUS

The duties of the Committee on Legislation and Bylaws can be rather demanding since not only must its members attend to the legislative needs of the Association but they must also keep a watchful eye on provincial and federal legislation that has implications for nursing. **Sister Madeleine of Jesus** has accepted the chairmanship of this busy committee for the new biennium. She is the director of the University of Ottawa School of Nursing and is extremely active in nursing circles. Participation in the work of the national committees is not new to her. Sister was a member of the finance committee during the past biennium and was also representative of the Ontario Nursing Sisterhoods to the CNA executive. She was re-elected to this latter position at the post-convention Executive Committee meeting in June.



SISTER M. FELICITAS

Sister Mary Felicitas, director of nursing, St. Mary's Hospital, Montreal is the new chairman of the Journal Board of *The Canadian Nurse*. Her unfailing interest in professional affairs, her extensive experience in national committee work — she was chairman of the Committee on Nursing Service 1958-60 — and her familiarity with the work of the *Journal* as a member of the Board over a period of years have fitted her particularly well for this task. Sister obtained a B.S. degree in nursing education from the University of Ottawa and her Master's degree from Catholic University, Washington, D.C. where her high standard of scholarship won her Phi Beta Kappa recognition.



SISTER MARY IRENE

As representative of the Nursing Sisterhoods from the Maritime provinces, **Sister Mary Irene,** educational director, Charlottetown Hospital will continue to lend her support to the Executive Committee. She represented the Sisterhoods of this region most ably during the past biennium and has participated actively in the professional affairs of her province over a number of years,

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as chairman of various committees and finally as president of the A.N.P.E.I. A graduate of Charlottetown Hospital with a certificate in nursing education from University of Toronto School of Nursing, Sister has a deep concern for and interest in the preparation of nurses not only for professional duties but as good citizens.



SISTER HUGH TERESINA

To represent the Nursing Sisterhoods of the Western provinces we welcome **Sister Hugh Teresina,** director of nursing service, St. Michael's Hospital, Lethbridge. Born in Alberta, Sister went far afield to receive her professional training. She is a graduate of St. Joseph's Hospital, Glace Bay, N.S. and has her certificate in nursing service administration from the University of Toronto School of Nursing. After a number of years as assistant director of nursing at St. Joseph's Hospital, she became director of nursing service, St. Rita's Hospital, Sydney, N.S. Then she travelled west again, to take over her present duties. An active participant in professional associations, she is a past president of the Cape Breton and Victoria Branch, RNANS and of the Lethbridge Chapter, AARN.

Sister Florence Keegan, professor in nursing administration and clinical supervision Marguerite d'Youville Institute, Montreal will represent the Nursing Sisterhoods of Quebec for the 1960-62 biennium. Amer-



(Jac Guy)

SISTER FLORENCE KEEGAN

ican-born of Irish descent, she is a graduate of Edmonton General Hospital with her Master's degree in nursing education and nursing service from St. Louis University, Missouri. She is a former director of nursing and assistant administrator of Edmonton General Hospital, positions which she held immediately prior to coming to the Institute.

She has taken an impressive part in the work of national and provincial groups since her arrival in Montreal. This has included membership on the Committee on Studies of the Canadian Conference of University Schools of Nursing as well as on the Special Committee that has recently completed "The Head Nurse Manual." In recent months she has acted as a regional visitor for the Pilot Project in New Brunswick and Prince Edward Island. Apart from her duties in connection with the students of Marguerite d'Youville Institute and her committee activities, Sister manages to find time to organize and direct special study days and institutes on nursing service on request of hospitals both within and outside the province of Quebec. She has also contributed to the courses in hospital administration set up for the public health nurses and doctors from the School of Hygiene, University of Montreal.

Enthusiastic, capable and energetic, Sister Keegan will represent the Quebec Nursing Sisterhoods most efficiently and will be a valuable member of our Executive Committee.

Studies serve for delight, for ornament, and for ability. — FRANCIS BACON

Statistics are like alienists — they will testify for either side. — F. H. LAGUARDIA



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All Aboard for Australia

THE JUNE, 1960 issue of *The Canadian Nurse* contained information on the Twelfth Quadrennial Congress, International Council of Nurses to be held in Melbourne, Australia, April 17-22, 1961. This account has probably whetted your desire and stimulated you to dream of visiting this sunny, friendly continent, noted for its wealth of flora and fauna, and fulfilling a desire to attend the ICN Congress.

Should you be planning to attend the Congress, you will be especially interested to know that the CNA has planned a tour through Thos. Cook and Sons. The tour leaves Vancouver on April 2, 1961. On the way you will visit Honolulu, Fiji and New Zealand. Following the Congress you will visit Sydney, Australia, returning to Vancouver on April 26.

Perhaps it might be convenient to extend your holiday. If so, we recommend that you take advantage of the extension to this tour and visit Malaya, Thailand, Hong Kong and Japan, thus returning home by way of Honolulu and arriving in Vancouver May 18.

Tour fares will include: transportation, sightseeing, tips, hotel accommodation, meals, etc. Hotel accommodation in Melbourne and meals in Melbourne, Sydney and Honolulu are not included.

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Ottawa	1712	2681
Montreal	1712	2681
Saint John	1769	2738
Halifax	1772	2741

For further information, brochures and application forms are available on request from: **The Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.**

ICN News

As another Congress draws near we realize, once again, how fortunate we are to be members of one of the world's oldest organizations. In fact, the ICN is the oldest international association of professional women. As members of such an organization we are privileged to have representation on ICN committees. Miss PEARL STIVER, our general secretary has recently returned from England where she attended a meeting of the ICN Committee on Exchange of Privileges for Nurses. Miss LILLIAN PETTIGREW, executive secretary and registrar, Manitoba Association of Registered Nurses attended a meeting of the ICN Committee on Revision of Constitution and By-laws within the past year. During April, 1960, Miss ALICE WRIGHT, executive secretary, Registered Nurses' Association of British Columbia, attended a meeting of the ICN Membership Committee. Through such representation the Canadian Nurses' Association has the opportunity to assist with and benefit from the many activities carried out by the ICN.

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International Visitors

National Office has been pleased to welcome many nurses from other countries who have been able to plan visits to Ottawa as well as other parts of Canada. Among these are Miss M. SIMPSON and Mrs. G. DOHERTY of the Royal College of Nursing, England and Miss MARION WEST, editor, Journal for Industrial Nurses published by the Occupational Health Section, Royal College of Nursing.

Miss MARGARET STEWART, secretary, Royal College of Nursing, Scottish Branch participated in the Executive Secretaries' Conference held in Ottawa in September, during her visit to Canada.

Other visitors to Canada were Miss SHEILA KIRK of the Royal Australian Nursing Federation. Miss EDITH PREDDY, England, Miss MAVIS MITCHELL, Australia and Miss JOAN MACFARLANE from Scotland.

Executive Secretaries' Institute

The third institute for executive secretaries and registrars of provincial and national registered nurses' associations was held in Ottawa in September. Topics under discussion were Counselling and Guidance, Employment Relations and Office Administration.

Psychological Problems

The Ottawa Study Group on Psychological Problems in General Hospitals, under the chairmanship of SISTER MADELEINE OF JESUS, director of the School of Nursing, Ottawa University, has completed its report of the 15-month study.

The project was launched in 13 countries by the World Federation of Mental Health, the International Council of Nurses and the International Hospital Federation. The executive secretaries of the corresponding National Associations formed the Steering Committees in each country. The Ottawa Group had representation from the three hospitals, National Health and Welfare, the medical profession, social work and the Canadian Nurses' Association. Two psychiatrists and a director of a school of social work acted as consultants.

The study undertaken by this committee has been both challenging and valuable to each member and to each professional situation represented. It has also stimulated a desire to continue as a permanent interdisciplinary group to explore the multiple avenues of communication and to exert a more widespread influence in this area with total patient care as the main objective.

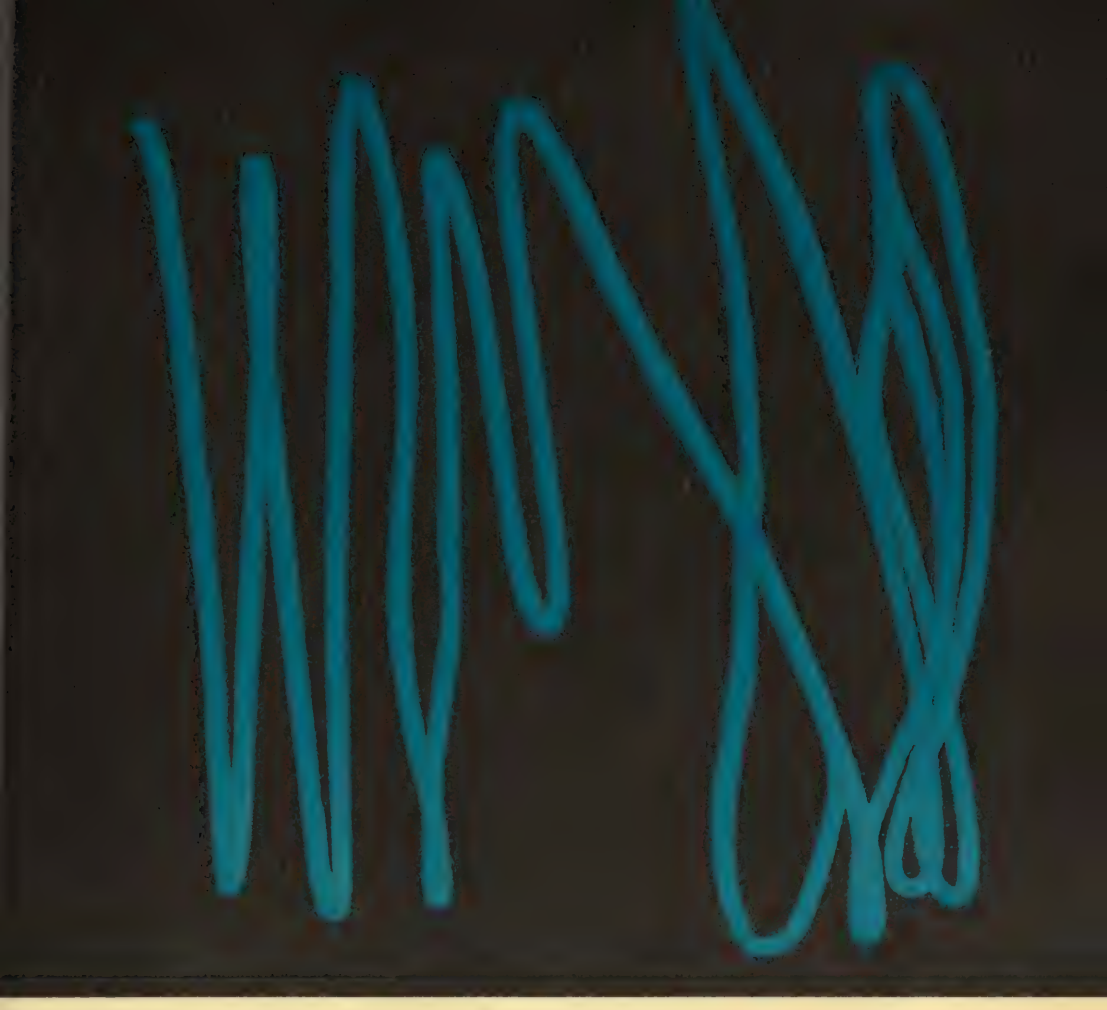
A meeting of representatives from the participating countries is being held in London, England this month to discuss the reports for an exchange of ideas and to correlate the findings and recommendations of all countries into a brief to present to an international committee of experts meeting later this year.

Miss JEAN DORGAN, consultant in social work to the Mental Health Division, Department of National Health and Welfare is attending the conference as representative of the Ottawa Study Group of which she was recorder. In addition to holding her Master's degree in social work Miss Dorgan also has her Bachelor of Science in Nursing.

Copies of the report are available in Canada from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa.

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In this world of hard knocks a sense of humor is a saving grace and the hide of a rhinoceros the best protection for a sensitive heart. — LOWELL BRETANO



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The Commonweal of Nursing

EDITH R. DICK

The closing address of the 1960 convention.

FOR A LITTLE WHILE at this closing session you are invited to direct your thoughts to the watchword chosen for the past biennium — Faith. The several synonyms of faith are known to you. Belief, trust, credence, confidence and reliance are some of them. It is within the meaning of a faith which breeds a sober confidence that you are invited to reflect. This is something far removed from an unconditional confidence that the future has only good things in store, or the easy optimism that things will somehow work themselves out.

You will recall the challenge given to us by Miss Electa MacLennan in *The Canadian Nurse,* March, 1960, when she asked "Have we kept faith with our profession, our public and ourselves?" She is zealous for our professional idealism and our standards of nursing education and service. She would have it that our heritage of vigor and courage as a profession entitles us to confidence in the future. She reminds us that the powers of healing are miraculous.

Faith and Belief

It is difficult to find a concept that will satisfy everyone because faith, as is the case with all important components of our lives, quite understandably defies easy definition. Faith is a union between belief and trust. Faith is chiefly personal. We have faith in a promise because it emanates from someone whom we trust. Trust is sentient. Belief, by itself, may be impersonal in the sense that we believe in a mathematical proposition because we know it is true. Belief is intellectual.

The belief which underlies faith is impregnated with the tension of perpetual intellectual effort that embodies a determination to know the precise nature of things. The poet has said that human kind cannot bear too much reality. Yet the knowledge that facts have been identified and understood carries with it a satisfaction that is balm for any hurt caused by the harshness of reality. Is it true to say that one of the predominant expressions at this biennial meeting has been a determination to seek out the static causes that may be limiting the realization of the aims of nursing education?

What of the Future?

In seeking direction for the future, the past and present meet. Arthur Bryant in his *English Saga* wrote: "The key to a nation's future is her past. A nation that loses it has no future." It has been suggested that a backward look is sufficiently reassuring to engender a feeling of confidence in the future. Past events have been referred to frequently throughout this convention. Over the years, the officers of our Association have given alert leadership. They have sponsored a general survey of nursing education; have published a guide for schools; have carried out a demonstration in basic education; have published policies for both education and service and, have reported on the Pilot Project for the Evaluation of Schools of Nursing. Perhaps the most promising aspect of this splendid report is the unmistakable evidence supplied by the director that everywhere the desire to improve the basic program is strong. When this concerted desire is examined at close range, there is brought into focus the true spirit of each school of nursing across Canada as many thousands of young women are helped toward their goal of becoming nurses.

We have been told that teaching in a school of nursing is not a competitive field. This fact constitutes a crucial situation with which we must deal. It also induces in us a feeling of gratitude to those nurses who, sensitive to the demands of our common task, come forward to seek qualifications as

Miss Dick who is director of the Nurse Registration Branch, Ontario Department of Health, gave this address at the final session of the Biennial meeting.

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teachers. One can imagine that there is an unwritten story behind the Pilot Project that is punctuated with anecdotes illustrating the very considerable individual contributions of those now manning our schools.

In terms of development in the practice of nursing, what are some intimations of the future? Many nurses would have it that we would be abdicating the role that is ours historically, traditionally and by inclination if, as nurses, we were to cease to give direct service to the person who needs nursing. They feel that it is only in this context that nursing can take its place with other professions.

It is interesting to learn that two new graduate programs are to be established on this continent to qualify the nurse as a practitioner in general nursing and in specialized nursing such as cardiovascular diseases or rehabilitative care of the chronically ill patient. Miss Frances Reiter of Teachers College will direct the programs. Miss Keeler, in reporting on the fact finding survey of the National Committee on Nursing Education has asked "Should we be thinking of geriatric or small hospital affiliation?" Surely these are intimations of the future.

Early in June, representatives of the university schools of nursing of Canada held their biennial conference. The story of the increase in enrolment in basic degree courses, of advanced preparation for faculty and of the near goal of graduate degree programs, has a significance for the commonweal of nursing. As we look toward the future, may we never forget the university as *the* institution in our social structure which exists to teach men and women how to search out the truth. We confidently and rightly look to our university school of nursing for leadership in our effort to prepare a competent practitioner of nursing.

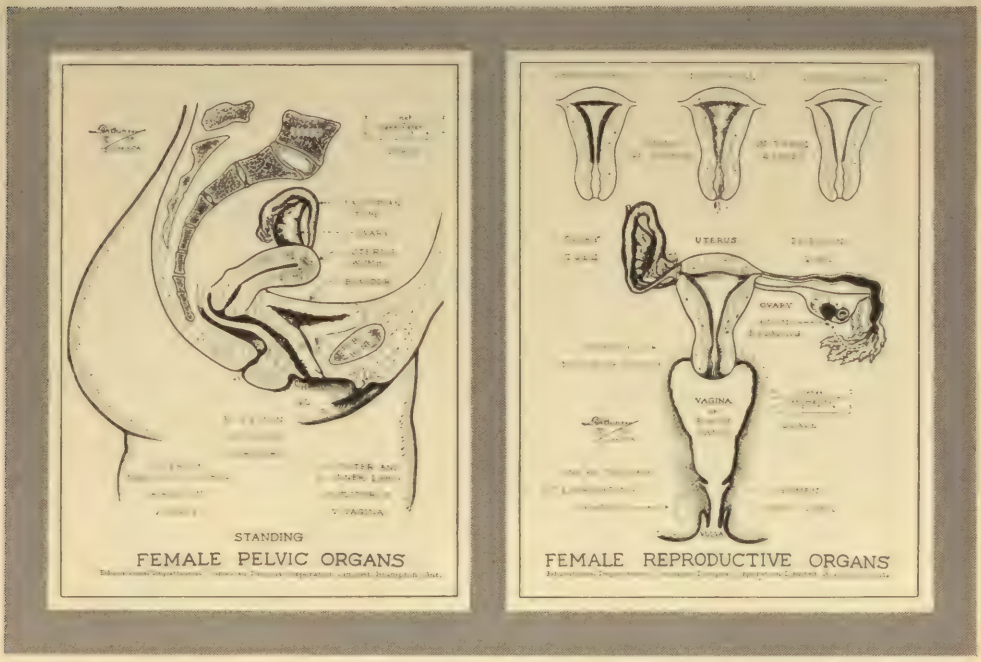
Faith and Trust

We have been speaking of the intellectual component in faith, the searching for facts on which to base our beliefs. We have done so to the temporary exclusion of the *trust* that makes faith so personal an attribute. Have we confidence in each other? Ours is a diverse group in certain respects. There are gradations in preparation and in status. There are differences in the nature of our responsibilities. Moreover, we share our task with the assistant nurse group to varying degrees. In spite of this, there is evidence to suggest that there is a growing mutual trust, a fusion of interests. This has been manifest in the sessions of this convention. It comes out forcefully in the verbatim comments in Appendix K of the report of the Pilot Project. There, members of staffs recorded their satisfaction in the conferences with the director of the Project and her associates. Here is one comment. "Through the discussions we were able to evaluate ourselves and this in turn has stimulated us to think how to improve our teaching methods." With modesty, let us record that nurses are showing aptitude in effective group work, not only with each other but with those of other disciplines. There has been sound leadership in this.

How well do we know our patients, those whom we serve wherever the citizen and his family are found — in schools, in homes, in industry, in hospitals. How well does the citizen know us? The public image of the nurse is probably too various to permit a comprehensive sketch. One hears of the social contract between the citizen and the professional person whereby the citizen is willing to support educational institutions to prepare workers whose services he needs and in return he seeks competent service and integrity. He probably expects more than average insight into the needs of the community. As a profession, can we not trust the citizen's ability to understand the essence of our discipline, a discipline that affects his well-being so directly? It is suggested that we need the good will of everyone because we serve them all.

When all is said and done, the public probably takes nursing service for granted. We are comfortable with this thought. There is a characteristic about nursing service that is somewhat uncommon. It is meted out in time as well as in kind. The citizen needs to know that nursing service is within his call and will stay with him when he cannot manage by himself. It is a continuing, supporting service that makes for mutual trust. Nursing,

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which is characterized universally by its availability and adaptability has indeed the opportunity to fulfill its purpose which Miss Nightingale, on one occasion, described quite simply — to help the patient to live.

Madam President, we thank you for having chosen the watchword Faith. It has challenged us to be true to our beliefs and humble in our trust. It has strengthened our confidence to plan and work together successfully.

SETTING THE STAGE

FLORENCE E. ELLIOTT

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the first of a series of three articles on this topic.

IN ATTEMPTING to direct curriculum development no one should try to provide a study group with a statement of what a curriculum should be or, to state with any degree of specificity, how curriculum development should be approached. In view of the many variables that affect nursing, the nursing curriculum and curriculum development in any school, it is wiser to speak only in terms of accepted principles and to provide examples of their sound application. To do otherwise is to invite the almost certain outcome of discouraging creativity and arriving at mediocrity. The most that a workshop session on curriculum can hope to accomplish, is to stimulate the participants to develop new ideas and to help them to gain knowledge and understanding that they can translate into action later.

An article in *Nursing Outlook* describes the approaches to curriculum revision taken by the faculty in one hospital school of nursing.

1. The *piecing* method in which scissors and the paste pot were used to make curriculum changes;
2. the *sifting* method in which many school announcements were reviewed in an avid search for new ideas;
3. the *analytical* approaches such as job analysis of social values which were used as a basis for evaluating and revising the curriculum.*

However, satisfaction and success came when the group decided to lay aside their preconceptions and to try an approach which for them was totally new. They focused on patients and nursing problems, forgetting at least in the beginning, traditional course boundaries, sequence and teaching methods. This example is illustrative of the kind of floundering that many faculties experience as they seek to improve their educational programs. Too few have the kind of leadership and academic freedom that encourages a "bold new approach."

The Task at Hand

Perhaps we can best set the stage by employing the first steps of problem solving. What is our task? In this instance, the ultimate objective of the Canadian Nurses' Association is to prepare a guide for curriculum development. The hoped-for result is a document that will be a useful tool for faculties in schools of nursing and that will encourage the improvement of nursing education.

Curriculum Guide of Yesterday

Curriculum guides of the past were somewhat different from the one we envision today. They were concerned with the curriculum *itself* rather than the *process of curriculum development.*

Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

*Gilmore, Laurene, "Curriculum Revision," *Nursing Outlook*, Vol. 7, pp. 204-206, April, 1959.

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For reasons that become understandable if viewed in the light of the history of nursing education these guides, although they made a contribution to progress in nursing education, eventually became a limiting factor. Instead of being used as guides, they actually became standard curriculums. The result was a high degree of stereotypy in educational programs in nursing. Why did this happen?

Nursing Education's Ancestry

A brief recollection of the background from which nursing education stems should help us to understand. Nursing got off on the wrong foot educationally speaking, through its beginning as essentially an apprentice training system. This was an inevitable beginning for a new field and not necessarily a bad one. Indeed, it was not too long ago that the aspiring doctor acquired his knowledge and skill by apprenticeship to a doctor who was practising and had established himself in the profession. The would-be doctor and his mentor recognized and accepted the fact that the primary reason for the arrangement was to provide an opportunity for learning. *Not so with nursing.* When the first "trained" nurses appeared they filled such a void, and so quickly demonstrated their worth that hospitals developed "training" programs for the purpose of providing nursing care.

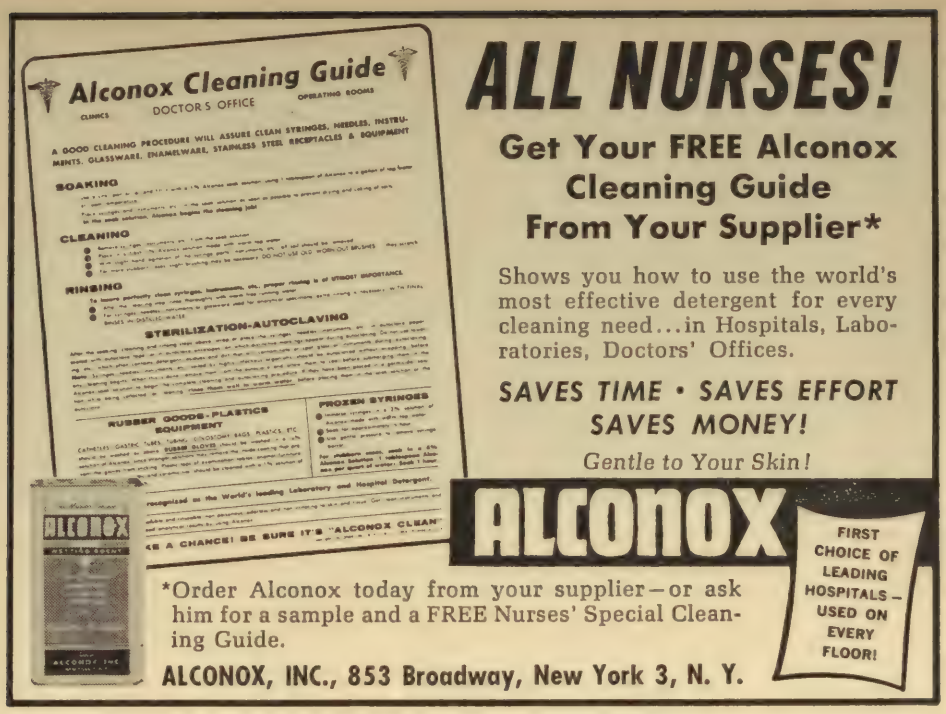
With the rapid advances in the field of medicine, nursing progressed and soon became aware that the necessary knowledge and skills went far beyond what could be acquired in apprentice training. Unfortunately, the concept that nursing students should provide service was firmly established. Through the years this has limited the degree to which nurse "training" programs have become educationally oriented. Just how far nursing education has moved is debatable. The fact that the school of nursing must use the hospital setting for its practice field — a situation in which everyone is oriented to the provision of service — is still a major factor affecting our educational programs.

Inheritance Inhibits Progress

Some of the reasons for the lack of speed with which we progress in nursing education can be found in the qualifications of faculty groups. In 1952, a study of 10,000 faculty members in schools of nursing in the United States revealed that only 68 per cent of the 6601 who reported had academic preparation of a baccalaureate degree or better, 16 per cent had a master's degree or better. When we consider that for the academic year of 1957-58 the total number of individuals who were awarded degrees that signified preparation for teaching in the field of nursing education, was 438, it seems reasonable to conclude that there has been no heartening change in the picture. Academically prepared instructors, who are themselves products of programs that were oriented to service needs, have difficulty reconciling their thinking to accept as right and proper the planning of learning experiences which meet educational objectives rather than the service needs of the clinical setting.

How much more difficult it is then for the instructor who has not supplemented her basic nursing program with any study that would help her to understand the validity of the arguments for educationally-oriented programs in nursing, or whose post-basic study has not had the content to provide this understanding. To further complicate the situation, the administrative head of the school, who is responsible for the leadership of the faculty, is frequently responsible also, for the nursing service of the hospital and is subject to the pull of two opposing purposes.

A factor of equal importance, directly related to the foregoing, is the situation in which the faculty functions in a setting that has little of the intellectual stimulation to be found in the academic environment. Its members operate somewhat as an outgroup among service-oriented personnel. The sad thing is, that the potential in any faculty group is tremendous. By and large, they are highly intelligent individuals who are intensely interested in their work and who are earnestly seeking to teach effectively. They keep themselves abreast of the progress in medicine, rise to the demands made on nursing by each therapeutic advance they meet in the hospital, and translate this into content for their teaching.



But how infrequent are their opportunities to intellectualize about nursing and nursing education! Indeed, in a hospital setting one can feel downright guilty about spending time on such a seemingly unproductive activity. Even those who conscientiously read the nursing literature are penalized by the lack of opportunity for the kind of stimulating and challenging discussions that encourage individuals to analyze and to evaluate what they have read. As a frequent result, they make only narrow interpretations and the understanding gained is most superficial. This is reflected in the way in which new terms enter their vocabulary and become freely used with little observable change in nursing education or practice.

These factors represent forces that profoundly affect developments in the field of nursing education. They cannot be ignored as the task of developing a guide is approached.

You may wish to add other factors, but the foregoing are at least partially explanatory of the reasons why many nursing curricula remain focused first and foremost on disease and its treatment. This continues in spite of the tremendous emphasis that has been placed on the patient and his nursing needs. These same factors also seem to account for two others: a. that the quantitative criteria for the curriculum (how many hours, how many weeks) still loom inportant and b. that nursing, as taught and practised, remains much narrower than its very great potential.

The Canadian Nurses' Association faces quite a challenge in its aim to produce a tool that will stimulate nursing school faculties toward creative endeavor. Within the faculties in schools of nursing lies the potential for much productive effort. How do we unleash the potential? The prerequisite is that we put aside our preconceptions, forget disease and its treatment, and think of *nursing*, what *it* is and how it can best be learned.



(Nursing Times)

European Overseas Tour

Book Reviews

Goodnow's History of Nursing by Josephine A. Dolan, R.N., M.S. 422 pages. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 10th ed. 1959. Price $5.00.

Reviewed by Miss Edith Fraser, Health Unit No. 5, M.H.C., Vancouver, B.C.

The author's purpose is given in the following statement. "It is hoped that this book will increase the understanding of the social sciences, art and literature and will permit the student to see the correlation between these and the care of the sick."

The first chapters deal with the care of the sick from primitive men to the great reform era of the 19th century. The cultural, social and religious life of ancient civilizations, and the influence exerted in the care of the ill, is related in a concise interesting way. Students will be somewhat surprised to read of a crude form of vaccination practised in China as early as the third century A.D.; of surgical procedures used in India and Egypt; and of "patient-centred" care taught by the great Hippocrates of Greece. The beginning of the Christian era brought great changes in the care of the sick. "Nursing was nurtured in the early Christian period and nurses have continued to contribute to our historical heritage ever since." A direct result of Christianity was the founding of many religious orders which contributed greatly to the progress of nursing. The historical background of many of these orders is given.

The second section of the book deals with modern nursing from the time of Florence Nightingale to the present day. As is natural in an American text, the history of nursing in the United States is related in great detail, but progress in other countries is also outlined and Canadian nursing is discussed quite fully. While acknowledging the V.O.N.'s great contribution to nursing in Canada, as a staff member of an official public health agency I take exception to the statement: "Practically all public health nursing in Canada is done under the Victorian Order of Nurses for Canada."

The great changes that have taken place in nursing all over the world since the Second World War are mentioned. The book ends with a description of the 11th International Congress of the ICN held in Rome, May, 1957.

It would be profitable for any nurse to read this book. A study of it should give the student a better understanding and appreciation of the evolution of the nursing profession. The author has shown clearly, the effect on nursing of social conditions, religious beliefs, customs and cultural patterns and thus achieved her objective.

Culture and Mental Health. Edited by Marvin K. Opler. 533 pages. Brett-Macmillan Ltd., 132 Water Street South, Galt, Ont. 1959. Price $8.75.

Reviewed by Mrs. Evelyn M. Furnadjieff, Clinical Instructor, Vancouver General Hospital, Vancouver, B.C.

From the modest editorial preface one learns that this book was compiled from a series of papers on social psychiatry. The editor has attained his stated objective by submitting these pioneering studies which show the effects of cultural patterns on mental health in world-wide perspective.

The subject matter is comprehensive. It features 23 original accounts based on the experiences of persons working in the social science and medical fields. The accounts deal with man, health, and community from every continent or island area in which notable work has been done. Barriers of allied sciences have been crossed to reveal fundamental relationships as they exist in the many cultures of the world.

The editor also outlines briefly the central theme of the volume — the variable effect of culture or cultural stress on mental health. The reader finds included thought-provoking case studies which stress this theme. These studies lead him to see mental health in its wide perspective. They emphasize the exploratory nature of current studies and the practical programs in social psychiatry that have been developed to date.

This book could be recommended as valuable source material for students doing research in the fields of anthropology, sociology, psychology and social psychiatry. Its usefulness would be limited in the basic school of nursing program.

Anatomy and Physiology by Edwin B. Steen, Ph.D. and Ashley Montagu, Ph.D. 314 pages. Barnes & Noble, Inc., New York. 1959. Price $2.50.

Reviewed by Miss Carol Reimer, Science Instructor, Misericordia Hospital, Winnipeg.

The authors state that their book is designed to meet the needs of students in various fields of medicine. I feel that there is too much detail for preclinical nursing students. Even as reference material, it might confuse them. I found this text of some value in preparing my lectures but I feel that too many terms are different from the terms generally used. The illustrations are inadequate, the labels of different structures are vague and the printing is too small.

The quick Reference Table to Standard Textbooks, is a helpful section.

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St. John Ambulance National Headquarters, Ottawa, has announced that the first Countess Mountbatten Bursary has been awarded to EVA FAIRWEATHER who has completed her first year at the University of New Brunswick School of Nursing. It is of interest that Miss Fairweather was a former St. John Ambulance Cadet. A close second was VIVIAN SHIER who has completed her first year at the University of Saskatchewan School of Nursing. JOYCE GILL, who has completed her second year at McGill University School of Nursing, ranked third. Nearly 40 applications were received from across Canada.

In making the selection, various factors were taken into consideration — education, personality and financial need. In view of the outstanding qualifications of these three students, it was recommended that this year in addition to the bursary, a special grant should be made to those coming second and third.

It is hoped to establish a Fund that will make possible an annual bursary of $600, in memory of the Countess Mountbatten of Burma, former superintendent-in-chief of the St. John Ambulance Brigade in the Commonwealth.

* * *

A recent study indicates a close relationship between anger and blood pressure. Persons who inhibit anger will have a higher diastolic blood pressure and peripheral resistance than those who more freely express it. The relevance of these findings to the thesis that essential hypertension may be the result of chronically inhibited angry feelings is clear. This disease is characterized by an elevated peripheral vascular resistance.

— *Health Bulletin,* North Carolina State Board of Health.

* * *

A new illustrated 30-page catalogue describing a variety of wheeled equipment for use in hospital maintenance and housekeeping may be obtained by writing to the manufacturers, The Paul O. Young Company, Line Lexington, Pennsylvania and mention *The Canadian Nurse.*

In Memoriam

Yvonne Valerie Cooper, an English nurse who had recently come to Canada, died in Edmonton, Alta.

* * *

Canadian nursing has lost one of its outstanding members with the death of **Agnes Jean Macleod** on August 3, 1960. In 1945 she was appointed matron-in-chief of the Treatment Branch, Department of Veterans' Affairs, and it was in that capacity that many nurses came to know her as she travelled about the country to the various veterans' hospitals and treatment units. Others will have memories of her as a principal matron, RCAMC during World War II when, with other Canadian nurses, she served overseas in the Italian and Mediterranean theatres, Belgium and France. In recognition of her distinguished military record, Major Macleod received the Royal Red Cross.

She was a graduate of the University of Alberta School of Nursing and had earned a bachelor of arts degree from the same university prior to professional preparation. Later she was to return to her school of nursing as its director, 1937-40, but in the intervening years she completed requirements for her Master of Arts and her certificate in teaching in schools of nursing at Teachers College, Columbia University. Always interested in professional organizations and activities, she found time in a busy life to serve both her provincial and national associations in executive offices.

Memberships in various clubs, including Soroptomist International Association, afforded her the opportunity to maintain a wide circle of acquaintances and friends for she loved people. But perhaps most of all, she loved her home in the Gatineau hills and the quiet times that she spent there.

* * *

Alice Evelyn (Smith) Simpson, a graduate of Groves' Memorial Hospital, Fergus, Ont. (formerly Dr. Grove's Hospital) died January 18, 1960.

An all-day program for nurses will be held at the American Heart Association's Scientific Sessions in St. Louis, Missouri, October 22, 1960. The highlight of the day will be a panel discussion on the "Total Nursing Care of the Patient with Myocardial Infarction." Registration forms are available from the American Heart Association, 44 East 23rd Street, New York 10, N.Y. or at the Kail Auditorium, St. Louis.

* * *

The most lovable quality that any human can possess is tolerance. It is the vision that enables one to see things from another's viewpoint. It is generosity that concedes to others the right to their own opinions and their own peculiarities. It is the bigness that enables us to let people be happy in their own way instead of our way.

— Rotary *Bulletin*

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Supervisor (Evening & Night Service) for 110-bed hospital. Starting salary, 1960: $330; 1961: $357, more if experienced. For information apply giving qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Clinical Instructor (Medicine) for school of nursing in interior of British Columbia. Postgraduate preparation required, experience preferable. B.C. registration required. Salary based on preparation and/or experience. Position available **September 1st., 1960.** Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Head Nurse for Medical Ward in General Hospital with school of nursing, located in the interior of B.C. Salary based on experience and/or postgraduate preparation. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in northwestern B.C. Starting salary, 1960: $285; 1961: $312, more if experienced. Residence available. For particulars apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Head Nurse for Pediatric Ward General Hospital with school of nursing. Able to assist with student teaching program. Salary based on experience and/or postgraduate preparation. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

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General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric, Operating Room & General Duty Nurses (Immediately) for new modern 125-bed hospital in central B.C., surrounded by magnificent scenery & excellent sporting opportunities. Starting salary B.C.R.N. $285 plus $14 increment with 2-yr. experience. Modern nurses' residence available. Apply: Nursing Supervisor, Regional Hospital, Prince George, British Columbia.

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Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital Alert Bay, British Columbia.

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Registered Nurses for Swan River Valley Hospital. Salary $280 with 4 semi-annual increments to $300, 40-hr. wk., 3, 8-hr. rotating shifts, 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Recreational facilities include golfing, fishing, swimming, curling, etc. Apply to: Swan River Valley Hospital, Swan River, Manitoba.

NOVA SCOTIA

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Volunteers for organization & direction of an extensive volunteer program in large General Hospital. Please apply to: Assistant Administrator Nursing, Ottawa Civic Hospital, Ottawa 3, Ontario.

Supervisors (Afternoon & Night), **Registered Nurses** (Extension Units), **General Duty Nurses** (Medical, Surgical & Obstetrical Units) for new hospital in centre of Seaway valley. For applications & enquires apply: Director of Nursing, Winchester & District Memorial Hospital, Winchester, Ontario.

Clinical Instructor for Pediatrics in 369-bed hospital with an approved school of nursing. 40-hr. work wk., 3-wk. vacation & statutory holidays. Fringe benefits. Salary will be based on qualifications. Experienced applicant preferred. Apply to: Sister C. Maitre, Director, School of Nursing, Hotel-Dieu Hospital, Windsor, Ontario.

Registered Laboratory Technician for new 58-bed hospital with new equipment in laboratory. Apply to: The Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

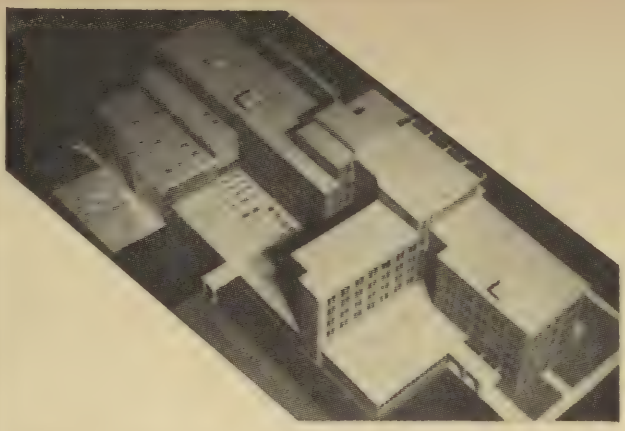
Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses & Certified Nursing Assistants needed to open new 165-bed wing in a 365-bed General Hospital located in suburban Toronto. Good salary, personnel policies include 5-day work wk., 8 statutory holidays. R.N. vacation after 1-yr. - 3-wks. Cert. N.A. - 2-wks. Living-in accommodation. Apply to: Director of Nursing, General Hospital, Scarborough, Ontario.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $270, 40-hr. wk., 14 days sick leave, 8 statutory holidays, 4-wks. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.



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Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays. Full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital. 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Graduate Nurses, Certified Nursing Assistants for General Duty for new 58-bed hospital. For information please write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3 500-$4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street City Hall, City of Oshawa, Oshawa Ontario.

Public Health Nurse (Qualified - Catholic) for St. Elizabeth Visiting Nurses' Assn. Minimum salary: $3,600, annual increment. 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto, 2, Ontario. EM. 8-1863.

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Assistant Matron with postgraduate, or experience in administration nursing service, for 140-bed hospital with building program in operation. For further information apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

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Evening Supervisor (Experience in ward supervision as a minimum), **Assistant Supervisor** (Experience in supervision required), **O. R. Supervisor** (Postgraduate course or experience in supervision of O.R.), **Registered Nurses** (General Staff). Salary scale of ANPQ. Write to: Director of Nursing, Lachine General Hospital, Lachine, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

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Operating Room Supervisor with postgraduate training, for 180-bed hospital. Average monthly surgical load - 157. Basic Salary $335 per mo. Duties consist of administration of department & educational program of students in department. Apply stating qualifications & experience to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Obstetrical Supervisor & Nursing Arts Instructor for 225-bed General Hospital, good personnel policies. For further information contact: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Registered General Duty Nurses (2) for modern 7-bed company hospital. Salary $315 per mo., $10 accredited postgraduate courses, overtime paid, $25 increment after 1 year. Full maintenance, transportation paid from point of hire in exchange for 1 year service. Group insurance & attractive vacation benefits. Excellent recreational facilities, boating, fishing, swimming, bowling, etc. Apply: Miss N. Prefontaine, R.N., Matron, Gunnar Mines Hospital, Uranium City, Saskatchewan.

General Duty Nurses for 14-bed Elrose Union Hospital. Salary $280 with yearly increments full maintenance in residence for $34.50, 40-hr. work wk. Apply: J. V. Nouch, Elrose, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi. from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses: Why not come to California this winter? At the Los Angeles County General Hospital salaries start at $375 per mo., & openings are now available on the Obstetrical, Medical & Surgical Services. If you are eligible for California registration & can speak & write English, write for full details to: Evelyn Nina Spees, R.N., County General Hospital, 1200 North State Street, Los Angeles 33, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.



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For expanding 374 bed General Hospital located on Long Island Sound just 45 minutes from New York City.

- Starting salary $355, annual increases for four years.
- $15 bonus paid for each night on call.
- Paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.
- Scholarship aid available for continued collegiate study.

Apply: Operating Room Supervisor

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Staff Nurses — San Joaquin General Hospital, a teaching hospital with internes, residents, & school of professional nursing. Positions available on most services on all shifts. Starting salary $376 per mo., differential for evening & nights. Laundry uniforms $5.00 per mo., liberal personnel policies, living facilities for single persons on hospital grounds. Contact: Personnel Director, 732 East Main Street, Stockton, California.

Registered Nurses for General Duty, obstetrics, operating room & emergency. Beginning salary: $330 per mo. $10 differential paid for afternoon & night shifts, also for obstetrics, nursery & operating room. 40-hr. wk. Liberal vacation policy, sick leave, holidays. Paid health & life insurance. Please write: Mrs. Doretha Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Director of School of Nursing for 200-bed J.C.A.H. accredited General Hospital. State approved diploma school seeking N.L.N. accreditation. Average enrollment, 65 students. Master's degree in nursing education & experience as educational director preferred. Salary commensurate with background. Liberal personnel policies. Apply: Rev. Carl H. Grathwohl, Administrator, Evangelical Deaconess Hospital, 3245 East Jefferson Avenue, Detroit 7, Michigan.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Graduate Nurses for General Hospital & Infirmary, 17 mi. west of downtown Detroit, Michigan (Choice of General or Psychiatric Duty). Salary: $410-$450 per mo. 40-hr. wk. Up to 15 days vacation after first year, plus 11 holidays. Liberal sick leave, retirement & social security. Must be graduate of accredited Canadian nursing school. Write: Director of Nursing (either General, Infirmary or Psychiatric), Wayne County General Hospital, Eloise, Michigan.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

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QUALIFICATIONS:

AT LEAST ONE YEAR'S EXPERIENCE IN PSYCHIATRY

SALARY:

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(2) Medical Unit —
Apply to:
Superintendent of Nursing, Nora-Frances Henderson Hospital, Hamilton, Ontario.

(3) Medical — Surgical — Pediatric Unit & Operating Room —
Apply to:
Director of Nursing, Hamilton General Hospital, Barton Street East, Hamilton, Ontario.

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OPERATING ROOM

Salary range $270 - $305

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Registered Nurses (Immediately) for newly opened 25-bed hospital in busy pulp mill town of 3,500 people, near Jasper National Park, just west of Edmonton on main highway & C.N.R. line. New nurses' residence. Salary $275 with $35 deductible for maintenance. Increments every 6-mo., M.S.I. & Blue Cross Groups in operation. Apply to: Mrs. Grace Allen, R.N., Matron, Municipal Hospital, Hinton, Alberta.

QUEBEC

Operating Room Nurses for modern well-equipped department in 140-bed General Hospital, no rotation, but required to take night calls. Good personnel policies & salary in accordance with ANPQ recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

BRITISH COLUMBIA

Director of Nursing for 109-bed B.C. Hospital. Salary open & dependent upon qualifications & experience. For full particulars, apply stating qualifications, to: Administrator, General Hospital, Prince Rupert, British Columbia.

Operating Room Nurse for 109-bed hospital in northern B.C. Salary $285-$342 plus on call pay, 1961 salary $312-$374, P.G. $10 extra. Room & board $50 per mo., travel allowance, welfare plan. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Registered Nurse for new 26-bed hospital in the Fraser Canyon 100-mi. east of Vancouver, B.C. Basic salary $285 — shift differential, 40-hr. wk., 28-calendar days' annual vacation. Accommodation available in a new nurses' residence. Positions available December 1st. Apply: Director of Nurses, Fraser Canyon Hospital **Hope,** British Columbia.

Registered Nurses for new 50-bed hospital with new nurses' residence. Salary $285 per mo. with annual increments if B.C. registered; $270 per mo. for non B.C. registered. 1-mo. annual vacation, sick leave benefits. Board & room $50 per mo. **Laboratory Technician** also required. Please address all replies to: Director of Nursing, Terrace & District Hospital, P.O. Box 1297, Terrace, British Columbia.

MANITOBA

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses, min. $281 - max. $319 per mo. with $10 additional for evening duty; for Licensed Practical Nurses min. $218 - max. $242 per mo. 8-hr. duty (day, evening or night), 40-hr. wk. Must be registered or licensed in Manitoba. Apply in writing to: The Director of Nursing, Municipal Hospitals, Winnipeg 13, Manitoba.

ONTARIO

Director of Nursing for new 150-bed General Hospital just completing new addition. Certified Nursing Assistants' training school planned. Hospital located in large resort area. Apply giving full particulars & salary expected, to: Administrator, Ross Memorial Hospital, Lindsay, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Deduction for room & board $30. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

U.S.A.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40-hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

General Duty Nurses for 197-bed hospital expanding to 325-beds located in Elizabeth, New Jersey. This will lead to many opportunities for advancement. Located 20-mi. from New York City, Elizabeth is serviced by the Pennsylvania (23 minutes from Penn Station, N.Y.) & Jersey Central Railroads & is adjacent to the New Jersey Turnpike & Garden State Parkway . . . affording excellent commutation conditions. For further details, please write: Leon S. Lewandoski, Personnel Director, St. Elizabeth Hospital, 204 South Broad Street, Elizabeth 2, New Jersey.

Attention! General Duty Nurses 400-bed fully accredited County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, paid holidays, pd. sick leave, retirement plan, social security, & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Increase in 6-mo. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for positions in Hospitals, Outpost Nursing Stations and Health Centres in the Provinces, Eastern Arctic, Northwest and Yukon Territories.

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(2) Public Health Nursing Supervisor I —$4,620 to $5,160 per annum

(3) Directors and Assistant Directors of Hospital Nursing Services:
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- b) Classification II —$4,350 to $4,860 per annum
- (c) Classification I —$3,900 to $4,560 per annum

(4) Public Health Staff Nurses —$3,600 to $4,050 per annum

(5) Hospital Staff Nurses —$3,300 to $3,750 per annum

(6) Certified Nursing Assistants, Licensed Practical Nurses and Nurses' Aides: up to $2,400 per annum depending upon qualifications and location of positions.

- Room, board and laundry in residence at reasonable rates. Statutory holidays. Three weeks annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.
- Special pay and leave allowances for those posted to isolated areas.

For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

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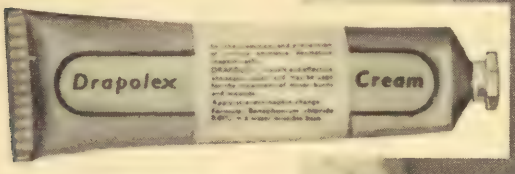
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Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso.
Circulation Manager: Winnifred MacLean
1522 Sherbrooke Street West, Montreal 25, Quebec

Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
U.S.A. & foreign: one year, $3.50; two years, $6.00.
Single copies 35 cents.
For subscribers in Canada, in combination with the
American Journal of Nursing: 1 year, $8.00; *Nursing Outlook:* 1 year, $7.00.
Make cheques and money orders payable to The Canadian Nurse.
Change of address: Four weeks' notice and the *old* address as well as the new are necessary.
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Between Ourselves

There is a well-known saying to the effect that if you want to have a job done quickly and thoroughly, try to find a very busy person. She will almost always find a way to fit a new assignment into an already full program.

Certainly, this comment is applicable to our guest editor, SHEILA MARGARET NIXON, A.R.R.C. When, nearly two years ago Miss Nixon accepted the obligation to serve as Editorial Adviser to *The Canadian Nurse* for the province of Manitoba, she was the director of nursing of the 232-bed Children's Hospital in Winnipeg and first vice-president of the Manitoba Association of Registered Nurses. Now, though she has moved into the presidency of the MARN and is nursing consultant with the Manitoba Hospital Services Plan she is still our Adviser. In that capacity, Miss Nixon secured the cooperation of the group of medical and other personnel who have contributed most of the articles on aspects of nutrition that comprise this issue.

Miss Nixon had already had a host of interesting experiences before she began her nurse's training at Toronto General Hospital. During World War II, she gave up the business career she was building for herself to join the Women's Division of the Royal Navy. Her decoration was awarded for meritorious service with the British Red Cross in Egypt and England. After graduating from T.G.H., Miss Nixon went directly to university and secured her Bachelor of Science degree from the University of Western Ontario, followed by her Master of Arts from Teachers College, Columbia University. A member of both the Winnipeg Philharmonic Choir and her own church choir, she still finds time for many sidelines of interest — not the least of which is solving difficult crossword puzzles!

* * *

Why should we devote almost all of an issue to a variety of aspects of nutrition? Every adult has some knowledge of foodstuffs, of the importance of a balanced diet that contains adequate quantities of vitamins and minerals, of the risks inherent in unwise reducing diets, of the various dietary fads that offer panaceas for "hidden hungers." But we question if even nurses have ever stopped to think of the multitude of sources of sodium, for instance, that the patient on a sodium-restricted diet must avoid. It certainly requires much more care than just to eliminate common table salt — sodium chloride.

And what about food poisoning? That oldtime bogey called "ptomaine poisoning" still pops up now and then in the daily press — and occasionally in a nurse's conversation — despite the fact their scientific background of information should remind them that the ptomaines are the end products of the decomposition of proteins. They should never be confused with those bacterial products that cause food poisoning.

* * *

The author of "A Capricious Appetite" has some very definite ideas on the role of the married nurses in the community. We have suggested that she write another article for us in the near future outlining the ways in which she thinks these capable women who are no longer active in nursing might put their knowledge and abilities to work in their own neighborhoods. Watch for another article by MRS. MARY GROOME next year, we hope.

* * *

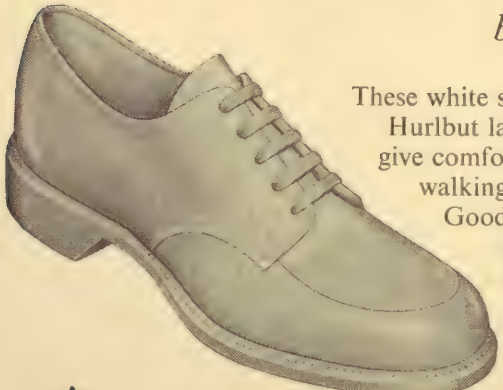
The **Cumulative Index,** listing all of the articles that were published between January 1955 and December 1959, by author, title and topic, is now ready for distribution. While its greatest usefulness is undoubtedly in the school of nursing library, individual subscribers may also procure a copy by completing the form appearing on page 969. A word of warning! Only 315 copies of this Cumulative Index have been prepared. Don't miss yours because you waited too long in ordering it. The price is $4.00.

One of the few remaining chores of cooking is scouring pots and pans, especially if they have burned dry. A new compound called *Stik-free* when applied to roasting and baking pans, ovens, griddles, waffle irons etc., and baked on for one hour at 400°F, will permit washing of a burned pan with soap and water, with no scouring. One generous coating will last from three to six months.



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Administration—Adults and older children: 1 or 2 tablets t.i.d. as required. Children 6 to 12 years: one tablet t.i.d. as prescribed.

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CUMULATIVE INDEX

1955-59

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Random Comments

Dear Editor:

Please find enclosed a money order for the renewal of my subscription to *l'Infirmière Canadienne.* At the same time I would like to convey my deep satisfaction in reading your pleasing and interesting journal.

After I have read it each month I always have the feeling of having spent time with an instructive and interesting good friend. I am always pleased to see it in the mail.

Please accept my grateful greetings.

YOLY COLLIER, California.

Dear Editor:

May I say how much I enjoyed the July issue of *The Canadian Nurse.*

I am a young married nurse with small children. Frequently people ask many questions concerning our work as nurses, such as communicable diseases and general questions concerning first aid treatment. I feel that many nurses like myself would appreciate articles of this nature.

I might suggest a page that would deal with "questions" and "answers" on current nursing problems. I am sure they would be extremely helpful to many nurses (especially the inactive nurses) who read the Journal.

Best wishes for the continuation of a fine magazine.

M. J. SMITH, Nova Scotia

Dear Editor:

I wish to express my admiration for the *Journal.* I hope it has a long life and that it will continue to spread its assistance and encouragement to Canadian nurses.

M. COMTOIS-CÉCYRE, Quebec

Dear Editor:

I would like to say I do enjoy the *Journal* very much. I think it does help to keep us up with nursing, especially we who are unable to nurse because of a family.

JUNE M. TAYLOR, Ontario

Dear Editor:

While doing private duty nursing in New York, I was called to nurse a man with cancer of the stomach. As soon as I came on duty he poured out his troubles to me.

His home was two miles from the hospital and his troubled and weary little wife travelled daily to visit him. He begged me

not to give him any more eggnogs, which he vomited instantly. He wanted so much to go home where his wife could care for him and prepare food that he could retain. The nurses and doctors seemed too busy or disinterested to be aware of his wishes.

When his doctor visited that day I told him what the patient had said — as a result he was discharged the following day.

This narrative indicates that "patient" conditions in the hospital are very impersonal. The patient is just "another" and treated accordingly.

What has happened to our hospitals and the nurses who took the Florence Nightingale pledge? The *human touch* and the kindly approach have been replaced by speed, restlessness and commercialism. The patient, especially the poor and aged, is completely forgotten.

I fully realize that a new era is upon us, changes are imminent, and adjustments called for that we must try to make. But in doing so, let us not discard the *worthwhile* ideals of the nursing profession.

MARY R. GAVIN, P.E.I.

Dear Editor:

Since June 1959 I have received a complimentary copy of *L'Infirmière Canadienne*. I want to let you know the pleasure I have in receiving the *Journal*, which is so interesting and of such value in my work.

Thank you for your kindness, it is much appreciated.

FERNANDA ALVES DINIZ,
Regional Officer for Nursing Care,
World Health Organization,
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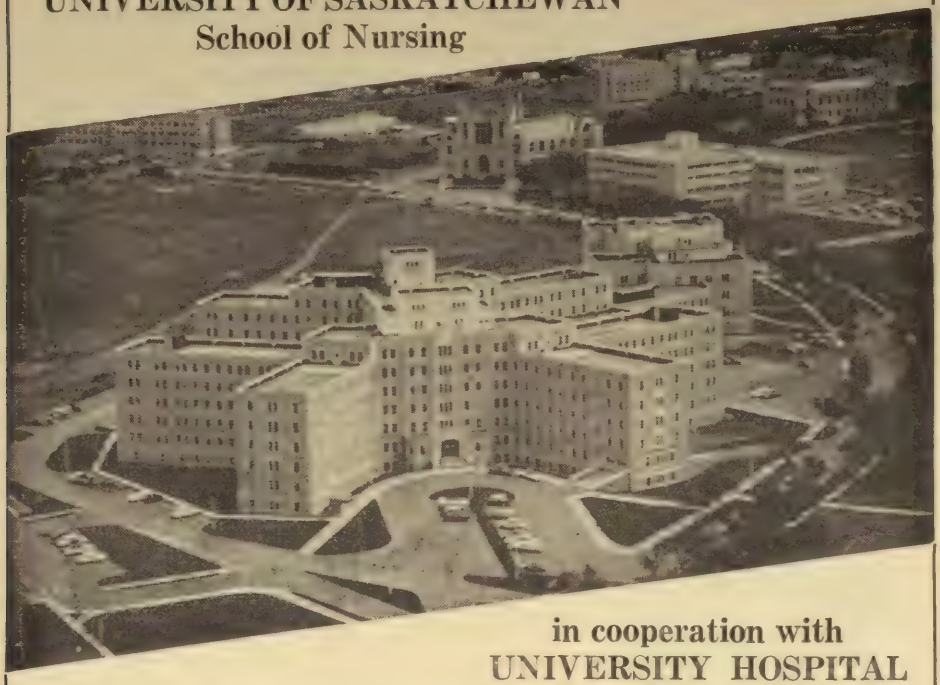
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By A. K. Geddes, M.D., Associate Professor of Pediatrics, McGill University, Montreal; Physician, Montreal Children's Hospital. 215 pages, illustrated. $4.50. *New!*

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Revised by Hulda L. Gunther, B.S., R.N., Director, St. Louis Unit, Shriners Hospital for Crippled Children. 209 pages. $2.50. *Fifth Edition!*

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By Audrey Latshaw Sutton, R.N., Formerly Clinical Instructor of Practical Nursing, Wilmington General Hospital, Wilmington, Delaware. 347 pages, illustrated. $3.50.

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VOLUME 56 NUMBER 11

MONTREAL, NOVEMBER 1960

THE NURSE CONSULTANT

IN THE PAST TWO YEARS, we have seen the introduction of hospital insurance plans in many of the provinces. As nurses, we must agree with the desirability of making hospital care available to everyone who needs it, but many of us have probably had doubts about the effect of such plans on the quality of hospital services. Some people may feel alarmed by the idea that financial support by governmental agencies must entail some measure of control. Nevertheless, it is evident that the responsibilities of expenditure of public funds include assurance that all sections of the public receive, in approximately equivalent quantity and quality, the services for which they are paying.

In January, 1959 the Hon. J. Waldo Monteith said, in part:

> We have seen to it that the hospital insurance program itself will foster the continuing of improvement in hospital care. Special machinery has been built in the provincial plans for this very purpose, but this machinery cannot do the whole job. A good deal of responsibility must still rest with the medical profession and hospitals. Experience shows that high quality care can best be insured by doctors and hospital authorities working together.

Part of this "machinery" is the appointment of consultants for various



SHEILA NIXON

areas of hospital operation. Most provinces now have at least one nursing consultant. While the responsibilities and duties of this position may not be clearly defined as yet, some functions are becoming apparent.

The first duty of a consultant is to become well acquainted with the field. This means extensive visiting of hospitals; learning about the conditions under which each institution operates; getting to know the people working in them. As nursing spreads its duties into so many areas — especially in small hospitals — the consultant cannot confine her interest entirely to nursing. She must become acquainted with problems in administration, purchasing, diagnostic and treatment facilities. This inevitably leads her to a realization of the difficulties imposed by the structural limitations of many existing hospital plants. The nurse learns to read blueprints so that she may make suggestions concerning required facilities. She works with other consultants on the approval of plans for building and renovation.

While the consultant is primarily concerned with service, the preparation of people to render service inevitably becomes of interest. She must be well aware of all programs and trends, not only in the education of professional nurses, but in that of other paramedical and auxiliary personnel. When necessary, she participates in educational programs, especially institutes, workshops and conferences for people in the hospital field. She may be called upon to assist with various publications and information services. Participation in research activities may also be expected of her.

Consultation is more than a one-way activity. It is far from being the "one-man show" administration of an expert in a problem situation. A consultant should be a channel for information and ideas to and from several directions. It is essential that the nurse consultant should be in close contact with her own professional associations in order to interpret the ideas of the organized profession both to governmental officials and to hospitals. She also must take back to the individual associations the problems that belong rightfully to their jurisdiction.

The most frequent problem encountered is the lack of prepared staff. No consultant can produce them. She can, however, encourage nurses to further their preparation. She can look for people who are ready for more responsibility, and who are seeking changes in position.

The responsibility of each professional association is to bring to the attention of employing governmental departments the qualifications that they should expect of the nurses appointed to the position of consultant. Wherever possible, the association should assist in finding suitable people. Once appointed, the consultants need our support and cooperation if they are to make their best contribution to the maintenance and improvement of the standards of nursing care in our hospitals.

Sheila Nixon
President
Manitoba Association
of Registered Nurses

Trans-Atlantic Exchange of Nurse Teachers

The Northern Ireland Hospitals Authority has been given a grant of $18,000 by the Rockefeller Foundation, New York, to meet the cost of a scheme that will provide for an exchange of nurse teachers. The two and a half year scheme will apply to the Toronto Western Hospital, the Massachusetts General Hospital, Boston and the Royal Victoria Hospital, Belfast.

Two nurse teachers from the Royal Victoria Hospital, will each spend a year on teaching duties, between Boston and Toronto. Similarly, nurse teachers from Toronto and Boston will each spend a year teaching at the other participating hospitals.

The scheme is intended to benefit the nurse teaching arrangements at the three hospitals and to produce information which will be of value to them and to other hospitals, in the instruction of student nurses.

ANEMIA

A. Zipursky, M.D.

Anemia is not a disease. It is the symptom of an underlying condition requiring careful investigation.

Etiology

Anemia may be defined as a reduction below normal of the concentration of hemoglobin in the blood. Such a definition indicates that anemia *is not a disease* but rather a single sign of disease. A fall in hemoglobin may result from a variety of disease processes. To understand the mechanism by which anemia is produced we must first understand the normal processes of red blood cell production and destruction.

The red blood cells, containing hemoglobin, are formed in the bone marrow. Iron, vitamin B_{12} and folic acid are necessary for the formation of hemoglobin and red blood cells. The cells so produced are released into the blood stream and survive for an average of 120 days. Destruction then occurs, particularly in the spleen, and the iron is saved to be used once more in hemoglobin formation. A reduction in hemoglobin concentration in the body can therefore occur for the following reasons:

I. Failure of red blood cell production.

II. Increased rate of red blood cell destruction (red cell life span is shorter than 120 days).

III. Loss of blood from the body.

I. Failure of Red Blood Cell Production

A. Nutritional failure

In certain conditions, the bone marrow may fail to produce blood simply because there are not enough nutrients available from which erythrocytes can be manufactured. In this group there are two main categories:

1. *Iron deficiency anemia*

Iron is necessary for the proper formation of hemoglobin. If iron is lost from the body (for example, through chronic blood loss) or if the demands for iron are excessive (for example, in pregnancy or rapid growth in infancy) the iron stores in the body will be depleted. There is then insufficient iron for hemoglobin formation. Since the marrow is unable to form hemoglobin properly, the red blood cells contain a decreased quantity of it and are accordingly small. When these cells are examined under the microscope they appear pale (hypochromic) and small (microcytic). Thus iron deficiency anemia is characterized as a hypochromic microcytic anemia.

2. *Deficiency of vitamin B_{12} or folic acid*

These substances are necessary for the proper development and formation of many body cells, including the red and white cells of the blood and the platelets. The formation of red cells in the absence of vitamin B_{12} or folic acid is markedly retarded. The mature erythrocytes in the circulation are very large (macrocytes). The red blood cell precursors in the marrow assume a grossly distorted appearance and are called "megaloblasts." Thus the anemia of vitamin B_{12} or folic acid deficiency is characterized as a macrocytic anemia with megaloblastic changes in the bone marrow.

Vitamin B_{12} is required in exceedingly small amounts in the diet so that a pure dietary deficiency of vitamin B_{12} almost never occurs. The absorption of vitamin B_{12} in the bowel is dependent on the presence of a specific substance liberated in the stomach and referred to as "intrinsic factor." If this substance is absent, absorption of vitamin B_{12} does not occur and anemia will develop. Primary deficiency of intrinsic factor and the resulting anemia is what we recognize as pernicious anemia. Folic acid deficiency occurs in a large variety of conditions where its absorption is interfered with (for example, sprue). Most of the folic acid required in the body can be formed in the bowel by bacterial action. If this

Dr. Zipursky is on the medical staff of the department of pediatrics, University of Manitoba and The Children's Hospital, Winnipeg.

is interfered with by prolonged antibiotic therapy, folic acid deficiency anemia may appear.

There are virtually no other nutritional deficiencies that commonly result in anemia in humans.

B. Bone Marrow Failure

A failure of red cell production may occur as a result of pathological processes within the bone marrow that prevent normal cell formation. Thus the marrow elements may be replaced by leukemic cells, tumor cells or fibrous tissue. They may also be destroyed by x-ray or drugs (aplastic anemia). In all of these conditions the marrow cannot form red cells but those cells that are present in the peripheral blood are of normal size (normocytic) and normal color (normochromic). The normochromic normocytic anemia under these conditions is usually associated with a depression in white blood cells and platelets.

C. Chronic Infection and Disease

In chronic infections and in certain chronic disease states (for example, rheumatoid arthritis, kidney disease or cancer) a mild anemia often develops. This is also a normochromic normocytic anemia with hemoglobin levels seldom lower than 9 gm.% (57% of normal). Anemia in these conditions appears to be due primarily to a failure in adequate red cell production by the marrow. There is seldom an associated fall in platelets or white blood cells.

II. Increased Rate of Red Blood Cell Destruction

When anemia occurs as the result of a shortened red cell life span within the body we refer to this as a hemolytic anemia. This may result from an intrinsic defect within the red blood cell or from some factor outside the cell that results in its destruction.

The intrinsic abnormalities of the red cell are inherited defects. Often the inherited defect not only manifests as a shortened life span but also as an abnormality in red cell shape or in the type of hemoglobin. Thus the cell may be spherical (hereditary spherocytosis) or elliptical (hereditary elliptocytosis). The hemoglobin in the cell may vary from the normal type that we refer to as Hemoglobin A to an abnormal type such as Hemoglobin S — the characteristic hemoglobin found in sickle cell anemia. In these disorders the defect may be found in several members of one family. When red cell destruction is increased in these disorders, most of the destruction may occur within the spleen. When this situation occurs, splenectomy is often curative. Otherwise, there is no treatment available for these hereditary forms of hemolytic anemia.

Under certain conditions normal red blood cells can be destroyed within the body. This is referred to as an acquired hemolytic anemia. A good example of this is erythroblastosis fetalis or hemolytic disease of the newborn. In this condition, anti-Rh antibodies pass from the Rh-negative mother to the Rh-positive fetus. These antibodies actively destroy the normal red blood cells of the infant. In other instances antibodies may arise spontaneously in an apparently normal individual and cause destruction of normal red blood cells. A similar condition occurs more frequently in individuals who are already suffering from some other disease (for example, disseminated lupus erythematosus or Hodgkin's disease).

III. Anemia Due to Blood Loss

This is the final and most obvious category of causes of anemia. Acute blood loss can result in the sudden appearance of anemia before the body can produce sufficient blood to replace that which has been lost. The anemia of chronic blood loss is an iron deficiency anemia.

Diagnosis

The diagnosis of the cause of anemia in a patient is dependent on a careful history, physical examination and adequate laboratory investigation. In this way the physician must endeavor to determine:

1. Has the patient lost blood? This can be determined by history and by repeated examination of the stools for occult blood.

2. Is the patient destroying his cells more rapidly than normal? In these cases jaundice may be present or there may be an increase in the products of red blood cell destruction (urobilinogen) excreted in the stool. More complex tests involving determination of the red

cell life span have become available recently. At times these are necessary to detect the presence of a hemolytic anemia.

3. Finally, is the patient able to form blood? This can be determined to some extent from an examination of the number of young red cells (reticulocytes) in the circulation. An increase in their concentration indicates increased red cell production whereas a decrease implies decreased production. An examination of a bone marrow aspirate is often helpful in that it can indicate any abnormal process within the marrow, (for example, leukemia, megaloblastic changes) that is interfering with red cell production.

One of the most important diagnostic tests in the study of anemia is an examination of the blood smear. In this way one can recognize abnormal erythrocyte shape (for example. spherocytes, elliptocytes) or abnormal size (macrocytes, microcytes). The significance of such findings has been mentioned earlier.

Treatment

There is no treatment for anemia just as there is no treatment for abdominal pain, jaundice or any other single sign or symptom of disease. Physicians do not treat signs or symptoms. They attempt to treat the disease itself. Therefore we first diagnose the cause of the anemia and then treat the disease producing it.

I should like to mention one group of diseases, the therapy of which seems most pertinent to this discussion. I refer to the nutritional deficiencies of iron, vitamin B_{12} and folic acid. In these conditions the treatment of the anemia is by specific replacement of the deficient substance. For iron deficiency anemia we prescribe iron only; for folic acid deficiency we prescribe folic acid only. The "shotgun" therapy of anemias with multivitamins and multimineral preparations is senseless, expensive and dangerous.

In conclusion, I should like to repeat that anemia is only a *sign* of disease. Its presence requires an active search for its cause. To treat anemia blindly with transfusions, medications, and so forth is wrong. The careful study of an anemia may reveal the nature of the underlying disease and it will certainly point out the most rational and direct method of therapy.

FOOD-BORNE DISEASES

J. E. Davies, M.B., B.S., L.M.C.C.

At the beginning of this century, the majority of epidemics were water-borne but as a result of improved sanitation of water supplies, this is no longer the case. Today, food is the most important factor.

In considering diseases that are food-borne, it is important to differentiate those illnesses that may arise either as a result of a variation in the quantity of food, in the composition of food or as a result of idiosyncrasy in the host. The former are essential nutritive diseases. The latter can be classified as allergic or metabolic diseases. For example, at times, urticarial rashes, migraine, gastroenteric upsets, and many other clinical syndromes may develop in certain individuals as a result of a sensitivity to a particular food. In this instance, there is nothing wrong with the food. It is simply a peculiarity of the individual. It is a situation where "one man's meat is another man's poison." The same is true in certain metabolic disorders such as celiac disease. A metabolic idiosyncrasy of the host is at fault and, in this specific instance, the protein, glutein, cannot be digested.

The operative word in this article is "borne" because food is thought of as a vehicle which, at times, can carry a noxious agent from its reservoir to the human host. It has often been

Dr. Davies is assistant medical health officer, City of Winnipeg.

said that, in most urban populations, there has been an actual increase in food poisoning since the last war. Certainly, there has been a change in our eating habits during the past 20 years. The increased number of catering establishments since World War II enlarged enormously the likelihood of infection. Furthermore, the mass manufacture of desiccated food products such as dried eggs and custard powders, enhance the risk. In the majority of instances, since food poisoning is often a mild disease, the health authorities are not notified. This makes it difficult to obtain an accurate overall picture of the prevalence of this complaint. There were 9,925 reported cases of food-borne diseases in the United States in 1958[1], but this figure is probably far below the actual number of cases that occurred.

Classification

Food may be contaminated by a chemical, radioactive or infected source.

Chemical and radioactive sources: In Canada, contamination from this source is largely obviated by the strict control enforced through the Food and Drug Act. The implications of the presence of radioactive particles, such as strontium 90 in milk, are only too well known. The levels of this radioactive element are being monitored all across Canada. The same strict control is apparent with regard to the chemical poisoning of food stuffs, but this is certainly not the case in many other countries in the world. The consequences of faulty supervision can be only too clearly and tragically witnessed in French Morocco today. There, in September 1959[2], as a result of the contamination of cooking oil with orthocresyl phosphate, a chemical used to lubricate turbo-jet aircraft engines, some 10,000 Moroccans were rendered pitifully and permanently paralyzed by food pollution.

Bacterial infection: In this group of diseases, there is a bacterial invasion and multiplication in the mucous membrane of the bowel with secondary spread to the mesenteric lymph nodes. In the case of typhoid there is spread to the bloodstream that produces a septicemia. The reservoirs of infection in these conditions are "carriers." These persons are usually either in a convalescent or a chronic stage of an illness. The most common mode of spread is through infection of water, milk or food.

Within the last six months there have been six cases of typhoid in Winnipeg. The disease developed in a group of school girls who had attended a Sunday School party. It later transpired that some of the egg sandwiches had been prepared by the grandmother of one of the girls. She had come in from the country to help prepare the food. She had had typhoid 30 years ago. She was later shown to be an unknown carrier but had carried on all these years without infecting either her family or her friends in the country. The removal of this lady's gall bladder resulted in a permanent cure of her carrier state.

Metazoal infection: Trichinosis is a not uncommon example of a metazoal food borne disease. It is confined to those who eat the uncooked or inadequately cooked flesh of infected animals. Last year there were six[3] reported cases in Canada, and to date

INFECTIVE AGENTS

	Types	*Sources*
A.	Bacterial infection	Bacteria that are the causes of specific infectious diseases (for example, typhoid, paratyphoid, dysentery)
B.	Metazoal infection	Metazoa that are the causes of specific metazoal diseases (for example, trichinosis)
C.	Bacterial food poisoning	1. Organisms of the Salmonella group 2. Staphylococcal infection 3. Botulism 4. Other organisms such as Clostridium *welchii*
D.	Plant and fungi	

this year the cumulative total of cases is 18.[4] The condition is readily preventable by adequate cooking. The larvae are instantly killed at 60°C. It is safe to say, therefore, that pork which has lost its natural pink color and has turned gray or brown with cooking is safe to eat. Prevention should be directed at the domestic level of cooking. This is the only certain way of preventing human infestation.

Bacterial food poisoning: It is customary to subdivide bacterial food poisoinings into those which result from the ingestion of a preformed toxin and those which result from the multiplication of an organism in the food and in the host.

STAPHYLOCOCCAL FOOD POISONING

This is the commonest form of food poisoning in Canada today. The symptoms are produced by the ingestion of a heat-stable enterotoxin that is given off by certain strains of staphylococcus. The organism is introduced into food by handlers who harbor the particular type of staphylococcus in the nose or on the skin. Not infrequently a carrier will be found to have a nasal or aural discharge, a boil or acneiform lesion on the skin. The organism grows well at room temperature and is not inhibited by sugar or salt. It will thrive in precooked ham, cream-filled bakery goods, potato salad, and similar foods.

The symptoms are usually explosive in onset. They consist of diarrhea, vomitting, and prostration and develop in an average of six to nine hours after the ingestion of the toxin. The severity of the symptoms depends both upon the potency and the dosage of the enterotoxin consumed. Antibiotics have no place in the treatment of this type of food poisoning. The illness is produced by the toxin that has been preformed in the food. Once the intoxication has passed, the symptoms will cease since there is no further bacterial growth in the host.

The severity of the symptoms and the number of persons involved is directly proportional to the length of time that the food has been allowed to remain under conditions that have been favorable for bacterial multiplication. Oddy and Clegg[5] described a staphylococcal outbreak that occurred in a group of miners as a result of eating pressed beef sandwiches. The food had been prepared and distributed to the miners working on the afternoon and evening shifts of the same day as preparation had taken place, and to another group of miners working on the morning shift of the following day. In this latter group there were 167 cases of food poisoning. No one in the two earlier shifts became ill.

BOTULISM

This a rare and often fatal form of food poisoning that results from the ingestion of a heat labile toxin formed from the spores of the organism Clostridium *botulinum*. The majority of outbreaks in the United States[6] are related to the consumption of improperly processed, home-canned vegetable such as string beans or beet root. The symptoms usually develop within 24-48 hours. They are referrable to the nervous system and not to the gastrointestinal tract. Constipation is a very common symptom. Initially, there is difficulty in swallowing and blurring of vision due to paralysis of the muscles of deglutition and accommodation. The paralysis spreads rapidly to all parts of the body including the muscles of respiration. This disease is prevented by ensuring that all home-canned vegetables are recooked before eating to destroy any toxins that may be present.

SALMONELLA FOOD POISONING

This is the second most common form of food poisoning. About 600 types of this microorganism[6] have been identified. Food may be infected from its source, for example, poultry, meat, eggs, or the organism may be introduced into food by infected food handlers or rodents. The food stuffs through which infection is commonly transmitted, in order of frequency are: processed meat, cream-filled buns, ice cream, shellfish and tinned fish, eggs, milk, cheese, fruit and vegetables. Food will most likely be infected if it is:

1. contamined
2. stored at a temperature that favors bacterial multiplication
3. if it is bland that is, alkaline
4. if it is moist
5. if it is inadequately cooked.

Prevention, therefore, is directed to

all of these factors. The symptoms are usually diarrhea and a febrile general malaise. They develop within 6-24 hours and may last from 2-4 days. A symptomless carrier state will persist for several weeks after infection. The number of secondary cases that could develop as a result of this state can be largely prevented if there is strict adherence to toilet hygiene and hand washing.

CLOSTRIDIUM *WELCHII* FOOD POISONING

This is the third most common form of food poisoning. It is only in recent years that bacteriologists have begun to look for this organism when investigating outbreaks of food poisoning or examining suspicious items of food. Meat is the usual vehicle. Infection develops when the spores of Clostridium *welchii* are able to germinate at room temperature after cooking. If cooked meat is refrigerated after use, the spores are not able to germinate and produce disease. The symptoms develop in 9-23 hours. They consist of stomach cramps and diarrhea. There is no fever and vomiting is rare. Fortunately the disease is universally mild. If these symptoms occur in an individual who has a history of having eaten boiled, stewed or, more rarely, roast meat, cooked some time in advance it should immediately suggest Clostridium *welchii* poisoning.

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IN THE GOOD OLD DAYS

(*The Canadian Nurse* — NOVEMBER, 1920)

When the nurse first appeared in our schools her function was thought to be mainly the detection of infectious disease. This, of course, still receives attention but we are striving to change the generally accepted assumption to the true idea that a school nurse means "health."

* * *

"As President, I would remind you that the magazine (*The Canadian Nurse*) is the property of the graduate nurses of Canada. What have you done to help and improve the magazine?

— EDITH MCPHERSON DICKSON

* * *

A course in public health nursing has been established at the University of British Columbia. This course is under the combined departments of nursing and public health connected with the University.

* * *

It is stated that a medical clinic for those who are well, is being established at London, Ont. It is proposed to have well people come to the clinic for examination, so that they may learn whether they are suffering from incipient disease, so as to secure treatment before it is too late.

* * *

The most important part of the nurse's education is her thorough instruction in practical methods. It is what she comes to a hospital to learn, and something she cannot get from books and lectures.

* * *

You are all aware of the difference between the old and new way of teaching nursing. In the old way the probationer was put at once in a ward to do as best she might the work of a junior nurse . . . In the new method the pupil is under an instructor chosen especially for her ability to teach . . . An objection to this (latter) method has been suggested, and that is the possibility of the patient being so much material for the benefit of the nurse, which attitude is far from the ideals of our profession.

Interviewing the Patient about Diets

BETTY THOMAS, B.Sc. (H.Ec.), R.D.

The services of dietitians in hospitals have been available to doctors for many years but their use in private medical practice is a relatively new trend. It is becoming increasingly popular in various medical units.

A CONSULTANT DIETITIAN is a member of the medical team who assists the doctor in translating his dietary prescription into foods and menus for the ambulant patient. The responsibility for teaching a diet to a patient is assumed by the dietitian and thus saves the doctor much valuable time. Specific diets should not be referred to as "special" diets. They are simply variations of a normal diet for a special reason. They are therapeutic in that the right combination of foods produces a therapeutic effect. An intelligent approach to the diet by both the patient and the dietitian will help achieve this value. This involves education of the patient, correction of food habits and fallacies about food and gentle persuasion to accept the doctor's advice regarding the diet. Since food is such a universal subject, most people feel they are authorities on it. It is sometimes difficult to convince a person that he can or should change his present eating habits.

My work has to do mostly with therapeutic diets and general dietary instruction, if necessary. The Winnipeg Clinic is a private medical clinic staffed, at present, by 55 medical specialists and 174 non-medical personnel. The non-medical staff includes registered nurses, practical nurses, x-ray and laboratory technicians, pharmacists, physiotherapists, medical secretaries, a librarian and a dietitian. The function of the dietitian is to teach the diet prescribed by the doctor.

Diets Under Medical Supervision

The patient is seen by the dietitian after his medical investigation has been completed and only if the doctor requests that the dietitian instructs him in a particular diet. No one is given a diet unless it is ordered by a doctor. Each patient is seen individually. The interview lasts from 15 to 45 minutes, depending on the type of diet and also, to some extent, on the understanding of the patient. Copies of the basic diets are kept in readiness to avoid any unnecessary waiting. Any changes required are made on the spot to suit the individual patient.

Before a patient arrives for his diet instruction, it is necessary to know a few facts about him. A quick glance at his medical history will give an overall picture of the person to whom you will be talking. Such information as occupation, age, living accommodation, language difficulty and diagnosis are important in explaining a diet. Acceptance of a diet varies greatly. Basically, no one likes to be told what he can eat. One common reaction to the doctor's decision to place his patient on a diet is that the patient feels that he will starve to death regardless of the type of diet that he is to have. A friendly smile and a cheery word as you greet the patient will help to dispel any developing hostility, although some people remain resentful throughout the interview.

Initial Approach

The first step in the interview is to find out if the patient fully understands why the doctor wants him to have the diet. He will have been told this already but if the dietitian can reiterate the reason, the patient feels that there is indeed teamwork involved in his medical management. The reason for the diet is repeated briefly, bringing his particular condition into the explanation. The patient is then asked what he has been eating. This varies from just about everything to being afraid to eat anything at all. This part of the interview is very time-consuming but it gives a very good picture of what improvements can be suggested.

The diet itself is thoroughly ex-

Miss Thomas is consultant dietitian at the Winnipeg Clinic, Man.

plained and reasons given why certain foods are omitted. A complete understanding is not expected at this time but with the explanation in his mind, it is hoped that when the patient reads the diet again at home, it will become clear. For this reason, as much information as possible is given in printed form without being so voluminous that it discourages the amount of reading necessary. The diets include menus, recipes, calorie charts, lunch suggestions, seasoning suggestions, etc. Ways and means are discussed for adjusting the diet to the family's meals, packing lunches, travelling and managing meals when invited out. These situations can be solved without too much difficulty and without being obvious. The patient is encouraged to return or to telephone for any further information that he wishes. It should be made very clear that, for the best results, the diet must be followed carefully. On the other hand, the patient should not be made to feel enslaved by it. In most cases, the diet is a temporary one. If he knows that there is an end in sight, he will be more likely to follow the instructions for the time required.

The Immigrant Patient

Among the problems encountered in interviewing a patient, the language barrier is the most difficult with which to deal. If a patient does not speak English, he usually comes in with a friend who does. The diet is explained to the friend who, in turn, translates it to the patient. This is not always satisfactory since you are not entirely sure that the patient understands and also, the friend is unable to answer any questions that may arise later on. The Clinic employs an interpreter and, although this is still a three-way conversation, a more satisfactory explanation can be given.

With the increasing number of immigrants coming to Canada now, language has become less of a problem than the "home-land" customs that are becoming quite a consideration in planning diets. These people are reluctant to change their long-standing food habits, and indeed, seldom do. In some cases, our Canadian food does not agree with them. For the most part they find it too sweet and starchy. Even our bread tastes sweet to them. A happy medium between our food and theirs is the aim. Religious customs are taken into consideration too, and wherever possible they are respected. The one exception is with the severe diabetic in which case the dietary control must be meticulous.

Food Faddist

One of the most difficult persons to reason with is the food faddist. He has such hard and fast ideas about what he should be eating that no one can change his theories. In some cases, it is the very food fad that he has been following that has made medical aid necessary. With such extensive advertising these days, susceptible persons are quickly convinced by fantastic claims concerning food as well as other products. They tend to rush out and buy a supply of the particular item. There are hundreds of food fallacies on record such as "rice, plus a regular diet, cures high blood pressure," "lemon juice is a cure for arthritis," "if a certain nutrient is good for you, then more of it is better." These and many other similar ideas are denounced as untrue but the patient may refuse to accept the denunciation. The fact that such practices could be a hazard to their health is unbelievable to them. A general discussion on healthful eating habits is required, using Canada's Food Rules as the basis.

Obesity

Since obesity is Canada's number one nutritional health problem today, the majority of patients coming for diets are those who are overweight. They form an interesting group. They have various ideas about reducing, most of which are either erroneous or not practised, as witnessed by their continuing overweight state. The women far outnumber the men in this group. The need for reducing is more often therapeutic than cosmetic. Nearly all overweight people firmly believe that they do *not* overeat and that a diet will never work. These patients have a long list of excuses on which they fall back to avoid having to change their present food patterns. Probably the one used the most often is "my whole family is fat, it's hereditary." Another is "I digest everything so well that all the food I eat turns to fat," and "I eat

like a bird." The last one is true, however. Birds eat all day long! Many overweight patients have, at one time or another, tried a fad diet such as the "banana diet," "the egg diet," "the blitz diet," and liquid diets. They come to us still looking for a quick and easy way to shed their excess poundage. It is pointed out at the beginning of the interview that *there is no quick way to lose weight.* It is a long-term program and nothing but harm can be expected from a fad diet.

The approach to a reducing diet is the same as with all diets. Show the patient *why* he must lose weight: to relieve a backache, to lower blood pressure, to take the strain off such organs as his heart, to say nothing of his feet! Patients seldom connect overweight with their aches and pains. You try to convince him that it will not be nearly as hard as his friends tell him. Often, he will be learning to eat differently and not necessarily less.

The diets are designed to suit individual needs and occupations. They include one for people who have to travel extensively. When a suitable diet has been selected, it is explained word for word and, again, reasons are given why certain foods should be avoided. The distribution of the food is stressed. This is something which rarely occurs to a patient as being a factor in reducing. If a man dashes off to work with no breakfast and a sandwich for lunch, he will end up by overeating at his evening meal. Then he wonders why he isn't losing weight! The advent of television has contributed to the overweight condition of many people. This is discussed in relation to the reducing program. Patients are encouraged to correct bad food habits and errors in cooking. They are encouraged to come back and weight in at any time. Those who lose weight are only too pleased to come back and show off; those who don't, are not so eager!

Patent reducing plans are discouraged. They are not only expensive but they are also not suitable for a long-range program. Often the only thing that is reduced is the bank balance. Children are treated for obesity in much the same way as adults. The mother receives instruction in helping the child through avoiding forbidden foods and substituting low calorie foods for higher ones. Children have proven to be more conscientious than adults in following reducing programs if the mother cooperates well.

The Diabetic Patient

Time and patience are required in teaching a new diabetic patient. The diet is usually unlike any that he has ever encountered before. If the explanation is too technical, he will feel defeated before he even starts. The most common reaction of the patient when he is told that he has diabetes is, "How could this happen to me, I don't take sugar?" This and other myths about the cause of diabetes are quickly discounted. He has to be reassured that it is not what he has been eating that has caused the condition. The first interview is as simple as possible. The patient is told to try out the diet for a few days and then to return or to telephone in order to have any questions answered. There are usually many questions that have developed as he became familiar with the diet. A second interview is sometimes more valuable. The patient is over the initial shock of hearing that he has diabetes. He has begun to accept his condition. He will be more receptive, cooperative and anxious to know if he is following the diet correctly.

The Ulcer Patient

While some patients resent a diet, others are most grateful. Among the latter are the ulcer sufferers. They are delighted to learn what they can eat without running into trouble. These patients will know about some of the foods that have upset them but not about all of the ones that might have a similar effect. It is sometimes surprising to find out that their favorite food could be at fault.

Acne

Patients with acne make up a large number of the patients treated by diet. They are often adolescents who are very self-conscious about their condition and eager to learn what they should be eating. The present vogue of soft drinks, "chips," hot dogs and hamburgers is most damaging to these youngsters and it appears, sometimes,

that they eat nothing else. An acne diet is a simple well-balanced diet with emphasis on avoiding excessive fat.

Helpful Ideas

Occasionally a patient will turn up a new idea or a recipe that might be used for other patients. These are discussed and in most cases are accepted. An example of this is the gluten-free bread that must be used on a gluten-free diet. We have tried many recipes for this bread and had equally as many complaints about it. One day a patient came in with a recipe with which she had experimented and with a sample of the gluten-free bread. We found it much improved over any that we tasted previously. Her recipe was included in the diet. Patients on these unique diets sometimes feel a responsibility to do this experimenting so that others may benefit from their experiences. This is true in the case of allergy diets. Several of our recipes have come from patients who have had to omit certain foods and have found a suitable substitute. All suggestions from patients are welcomed and used whenever possible.

Teaching a person to change his way of eating is not just a matter of *telling,* but rather of *selling* the idea as well. Eating should be a pleasure and at the same time contribute to good health.

In Memoriam

Kate Maude Beckett, who graduated from Toronto Western Hospital in 1912, died in Toronto on August 3, 1960.

* * *

Emilia Ansa Bergman, who graduated from Regina General Hospital in 1932, died in Toronto on August 13, 1960. She had engaged in private nursing.

* * *

Simonne Biron, a senior student in the school of nursing of Notre Dame Hospital, Montreal, died on August 16, 1960, from injuries received in an automobile accident.

* * *

Annie Arnold Bishop, who graduated from Grace Hospital, St. John's, Nfld. in 1932, died there on July 11, 1960. Miss Bishop was in charge of the student health program at Grace Hospital for some time. She had been active in the committee work of the A.R.N.N. and was membership convener of the St. John's Chapter.

* * *

Helen Curliss, who graduated from Toronto General Hospital in 1934, died suddenly on July 16, 1960. On the staff of New Mount Sinai Hospital, Toronto, at the time of her death, Miss Curliss had worked at the Sunnybrook D.V.A. Hospital for many years.

* * *

Pearl Caldwell Graham, who graduated from Ontario Hospital, Whitby in 1932, died at Barrie, Ont., on July 18, 1960. Prior to her retirement in 1959, Miss Graham was director of nursing at Ontario Hospital, New Toronto. She had served with the Ontario Department of Health for 27 years.

* * *

Dorothy (Boyce) Donaldson, who graduated from Victoria Public Hospital, Fredericton, N.B. in 1941, died in July, 1960 at Roblin, Man. Mrs. Donaldson served with the RCAMC during World War II.

* * *

Agnes Margaret Hart, who graduated from Moose Jaw Union Hospital in 1930, died on June 27, 1960. A member of the staff of the Saskatoon Tuberculosis Sanatorium, ill health had forced Miss Hart to retire earlier this year.

* * *

Dorothy Holmberg, a graduate of Royal Jubilee Hospital, Victoria in 1945, died in Denver, Colorado on June 22, 1960. She was studying at the University of Colorado at the time of her death.

* * *

Isabelle Frances (Carey) Irwin, who graduated from Toronto East General Hospital in 1936, died in Toronto on August 23, 1960.

* * *

Hazel M. (Wilson) MacIver, who graduated from Ontario Hospital, New Toronto in 1931, died in Toronto on June 20, 1960.

* * *

Loretta McGuire, who graduated from Lorrain School of Nursing, General Hospital, Pembroke, Ont. in 1927, died in Hampstead, N.Y. on August 5, 1960. She had engaged in private nursing.

What is the Sodium Restricted Diet?

VIVIAN M. BRUCE *and* ELIZABETH FENIAK

With improvement in the analytical methods for the determination of sodium in foods and other biological constituents, the sodium restricted diet has gained new prominence.

SODIUM IS AN ELECTROLYTE represented by the symbol Na. It occurs in plant and animal organisms as the ion Na+. Sodium complexes in living matter are unknown[4]. Restriction of sodium chloride or table salt is associated with the sodium restricted diet. Perhaps for this reason, the sodium restricted diet has been described by such terms as "salt free," "salt poor," "low salt." These terms are non-specific and confusing. They should be avoided. When a sodium restricted diet is indicated, it is not *salt* that is the factor to be restricted, but *sodium*. It is possible with the present average analytical tables to calculate the sodium content of the daily diet in milligrams.

Sodium functions in the body in the following ways[5]:

1. In maintaining osmotic pressure between the solutes of the extra-cellular fluid and the solutes within the cells.
2. As a buffer in conjunction with carbonate and phosphate, thus helping to maintain the pH of the blood within normal limits.
3. In the conduction of nervous impulses and muscle contractility.
4. In maintaining water balance of the body.

Water is retained or excreted with sodium in quantities to maintain the tonicity of body fluids.

Normal Sodium Requirement

How much sodium can be considered to be a normal requirement? An optimum level of sodium chloride in the adult human has not been established. The daily average intake estimated by the National Research Council is 7-15 grams (or 7,000-15,000 milligrams)[5]. Dahl reported that the effect of an excessive intake of sodium chloride resulted in hypertension[3]. He observed that primitive tribes had a low incidence of hypertension. Other evidence was obtained from animal experiments; from the relief of hypertension by salt restriction; from the incidence of hypertension among individuals on high salt diets. Over a period of 10 years, Dahl studied 75 essential hypertensive persons, normal persons, and persons with unrelated diseases. The diet given contained 100-150 mg. of sodium plus 4 grams of sodium in the form of pills. When the pills were removed from the diet, ¼ to ⅓ of the persons experienced a fall in blood pressure. Dahl recommended that the salt intake for persons with existing hypertension should be below 1-2 grams while the intake for non-hypertensive persons could be 5 grams.

Studies were carried out with rats to assess the chronic toxicity of sodium chloride. Ball and Meneely[1] maintained 546 male Sprague-Dawley rats and 21 female rats of the same strain on 10 levels of added dietary sodium that ranged from .15-21 per cent sodium chloride beginning at 5 weeks of age and continuing throughout their lifetime. Control rats were fed a diet that contained 5.6 per cent sodium chloride. After 19 months on the diet, 80 per cent of the rats that had been fed 9.8 per cent sodium chloride developed hypertension. After 15 months on the diet containing 14.0 per cent sodium chloride, all of the rats in this group were dead. Similar results were observed when a group of rats was fed diets containing 21.0 per cent sodium chloride for 9 months. Results of animal experimentation cannot be directly applied to human nutrition. However, observations of abnormal and disease states may contribute information that can be used in the determination of a recommended

Miss Bruce is the graduate assistant and Miss Feniak is associate professor in foods and nutrition at the University of Manitoba.

optimum sodium chloride intake for the adult human.

The principal loss of sodium occurs through the urine, skin and feces. The normal kidney conserves sodium. Approximately 6.0 per cent of the filtered sodium is excreted. The tubules of the kidney reabsorb the remainder of the sodium[6]. The tubular resorption is modified by the action of the adrenal cortical hormone. Dahl reported that during a 10-year period, ambulatory patients with essential hypertension who received 100-200 mg. sodium daily did not require sodium supplements.

Ingestion of Sodium

Sodium may be ingested through foods, water and medicines. Raw and processed foods have been analyzed for sodium. Sodium is added to a number of foods during processing. Considerable work remains to be done on the sodium content of foods. Sodium values for foods may vary with differences in variety, climate and soil.

In general, foods from animal sources are high in sodium. Meats, particularly organ meats, shellfish, eggs, milk and cheese contribute large amounts of sodium. Some vegetables such as carrots, celery, spinach, beet greens contain appreciable amounts. The relative sodium values of these foods, unsalted, are approximately as follows:

	approximate value milligrams
meat, 1 oz.	25
milk, 1 8-oz. cup	120
egg, 1	70
bread, unsalted, 1 oz. slice	9
butter, unsalted, 1 tsp.	1

Recently the sodium content of fish flesh has been studied by Thurston and Osterhaug[7]. They studied the effects of handling on the sodium content. Only when sodium compounds were added did the sodium content of the fish flesh change. One of the processes studied was the dipping of fish fillets in water to provide a protective icy glaze. When fresh water was used, there was no appreciable change in the sodium content. Information about the changes in the sodium content of foods during cooking is far from complete. Thurston and Osterhaug reported that there was no change in the amount of sodium during the baking of fish.

Sodium compounds that are added to foods will be designated on the food labels. The importance of reading food labels cannot be overemphasized in regard to the sodium restricted diet. Some of the sodium compounds found most frequently in processed foods are:

1. Salt (sodium chloride)
2. Baking powder (sodium carbonate) — used to leaven quick breads and cakes
3. Baking soda (sodium bicarbonate) — used to leaven breads and cakes
4. Brine (table salt and water) — used in the processing of food to inhibit growth of bacteria
5. Disodium phophate — used in some quick cooking cereals and processed cheeses
6. Monosodium glutamate — used to enhance food flavor; obtainable under various trade names
7. Sodium alginate — used in many chocolate milks and ice creams for smooth texture
8. Sodium hydroxide — used in softening and loosening skins of certain fruits and vegetables during processing
9. Sodium benzoate — used as a preservative
10. Sodium propionate — used to inhibit the growth of molds in breads and cakes
11. Sodium sulfite — used to bleach certain fruits to which an artificial color is to be added; may be used as a a preservative for some dried fruits.

Drinking waters may constitute a source of sodium. Sodium values can usually be obtained from the local health department. If the sodium level is such that appreciable amounts of sodium are being consumed, distilled water should be used for drinking and cooking. Water that has been "softened" can be suspected of containing increased amounts of sodium.

Certain types of medicines contain sodium: laxatives, pain relievers, cough medicines. These should not be used indiscriminately. The labels on tooth pastes, tooth powders and mouth washes should be carefully checked since they may contain sodium compounds.

Preparation of Low Sodium Diet

The restriction of sodium generally indicates the preparation of food without salt. Preparation of food should be relatively simple. Recipes containing significant amounts of high sodium foods, such as milk and eggs, should be avoided. Milk, a high sodium food, should be included in all low sodium diets in amounts varying with the degree of sodium restriction. On very low sodium restrictions, it may be necessary to curtail the amount of milk, or to substitute a dialyzed milk — one which has had the sodium ions removed.

On the extremely restricted sodium diet, careful planning is necessary in order to prevent deficiencies of other essential nutrients. Because of the restriction of meat and milk, protein, riboflavin and calcium are the nutrients most likely to be affected. Prolonged elimination of salt may mean reduced iodine intake. Other sources of this mineral must be provided.

The sodium restricted diet is lacking in the flavor normally contributed by the addition of table salt. It tends to be tasteless and unappetizing to the patient and, as a result, it is important to make use of other seasonings. The following common flavorings do not contribute significant amounts of sodium to the diet[5]:

allspice	cocoa	mint
almond extract	curry	mustard, dry
	garlic	nutmeg
basil	ginger	oregano
bay leaf	lemon juice	paprika
caraway	maple extract	peppermint extract
cinnamon	marjoram	sage
cloves		

There have been many types of salt substitutes devised. However, these should be used only on the advice of a physician, since the ion substituted for sodium (usually potassium or ammonium) may be physiologically unsuited to the patient.

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Thirty-eight patients from the gastroenterology ward of Wadsworth Veteran's Hospital were used to determine gastrointestinal blood loss during ingestion of aspirin. Their erythrocytes were tagged with Cr^{51}, enabling a quantitative measurement of blood present in the feces. Before administration of the aspirin all were losing less than 2 ml. of blood per day in the feces. After administration fecal blood loss rose in every subject. The increases ranged from 0.2 to 13.5 ml. per day and averaged 3.3 ml. per day.

The patients' gastrointestinal history, the type of aspirin, (tablet or alkaline solution), did not affect the outcome. Blood loss was less when antacids were administered with the aspirin.

— *Abbott Abstracts*

Now, for the first time, a new booklet about menstruation answers actual questions that have been asked by thousands of girls all over the country. Called "Accent on You," this booklet tells girls what they want to know about every phase of the menstrual process, and shows in simple, labeled diagrams how and why the cycle takes place. Its 24 pages of facts and pictures also cover questions about activities, exercise and dating and personal care. Available free of charge "Accent on You," is written specifically to help maturing girls understand that menstruation is natural, normal and merely a part of healthy womanhood. Mothers will find it helpful in explaining menstruation to their daughters. Address your request to Department CN — 360, Canadian Tampax Corporation Ltd., Brampton, Ontario.

Adult Requirement for Calcium

Elizabeth Feniak

How much calcium do adults require compared to children?

Functions

Calcium is the mineral element that is found in largest quantities in the human body. Approximately 1.5 per cent of body weight is calcium, e.g., 2 pounds in a 125-pound woman. Approximately 99 per cent of it is in combination with phosphorus in the bones and teeth. The balance exists in a fairly constant concentration in blood serum, partly in bound form with protein and partly in ionized form. The bone calcium functions to give strength and rigidity while calcium of the blood serum functions in the clotting of blood, maintenance of muscle tonus, cell permeability and nerve transmission[9].

Metabolism

Studies with radioactive calcium have contributed greatly to our knowledge of the metabolism of this mineral. Absorption occurs in the small intestine from which the mineral is carried in soluble form by the blood to all parts of the body. The calcium of the lattice-like trabeculae of the ends of the bones is the most readily available source of the mineral, although even the constituents of solid bone are in a state of dynamic equilibrium with constituents of the blood. Through regulation by the parathyroid gland, this reserve may be used to maintain a constant blood level.

Many studies on calcium absorption indicate a fairly limited and variable absorption of the mineral, with values usually occurring between 20 and 30 per cent and frequently lower. Absorbed calcium is excreted partly as soluble salts in the urine, partly in the feces. Fecal calcium also includes ingested calcium that was not absorbed.

One of the factors that influences the amount of ingested calcium that will be absorbed is the degree of acidity in the upper intestinal tract. The presence of oxalic and phytic acid in a food renders the calcium content of that food unavailable because of the resultant formation of insoluble calcium salts. Vitamin D is closely related to calcium and phosphorus metabolism and calcium absorption is improved when vitamin D intake is adequate. It has been shown also that an individual's established level of calcium intake affects utilization, a higher retention of the mineral being found in those accustomed to a very low calcium intake.

Requirements

Because of individual variation in absorption, and difficulties in the interpretation of data from balance studies, the establishment of a recommended level of calcium intake in adults has been difficult. For growing children, it has been possible to estimate weight gains due to bone growth and, with due consideration to percentage retention of the mineral, calculate the amount of dietary calcium necessary to take care of this demand. For adult needs, the balance technique has been the basis for establishing minimum requirements. This method compares excretion levels with intake. A positive balance, in which intake exceeds excretion, indicates storage of calcium and is normal in growing children, and pregnant and lactating women. A negative balance would be indicative of faulty metabolism with loss of bone stores of calcium. The healthy adult should be in balance with enough calcium being absorbed from food to meet daily losses of the mineral.

The minimum level of intake at which a positive balance occurs has been used as an estimate of the adult minimal calcium need. Sherman suggested 0.45 grams on the basis of early studies. Steggerda and Mitchell recommended 10 milligrams per kilogram of body weight (or 0.7 grams for

Miss Feniak is associate professor in Foods and Nutrition at the University of Manitoba, Winnipeg.

a 70 kilogram man). The dietary standards established for use in Canada and the United States have recommended calcium intake levels in line with these findings. The Canadian standard[1] designed to represent a minimal nutrient intake compatible with health, expresses calcium requirement as proportional to body size (0.55 grams for a 120-pound woman, 0.75 grams for a 160-pound man). The Recommended Allowances of the U.S. Food and Nutrition Board, that are intended to allow a "margin of sufficiency" above minimal requirements[4] so that all variations of requirement among the population at large may be covered, affirms its previously established allowance of 0.8 grams of calcium per day for adults (exclusive of pregnant and lactating women).[6] For the second half of pregnancy and during lactation, the Canadian Standard recommends the addition of 1 gm. above maintenance figures, the U.S. standard a total of 1.5 grams and 2.0 grams for the respective periods.

Dietary standards are estimates of the requirements of *average* healthy individuals and are designed to be used as a reference against which to assess the nutritional status of population groups or the food supply of an area. It is incorrect to use them as a rigid definition of the needs of any single individual, without due consideration of the wide range of individual variation that exists around any average figure.

Calcium Equilibrium on Low Intake

The figures used as standards in the U.S. and Canada are considerably above the intake of persons living in numerous underdeveloped areas of the world where milk supply is extremely low. Balance studies with these subjects give valuable information about minimal calcium for adult maintenance. Many such investigations report that individuals are maintaining calcium equilibrium on extremely low intake.

Ceylonese boys were found to be in positive balance on an intake of only 0.2 grams per day, absorbing and retaining from 34 to 89 per cent of the calcium in the food intake[7]. Ten Peruvian males, of normal stature and apparently healthy, who had been living on diets low in calcium for long periods of time, were found to maintain equilibrium on an average daily requirement of 0.1 to 0.2 grams. Their percentage ranged from 6 to 30 per cent. That the retention was not unusually high was taken as partial evidence that the men were not in great need of extra calcium[2].

Hegsted criticizes the use of the balance technique as a means of establishing a recommended level of intake[3]. The effect of the previous diet of the subject appears to relate very closely to the level at which calcium equilibrium is achieved. The more efficient utilization of a meagre calcium intake is referred to by many workers as evidence of physiological adaptation to a state of undernutrition. Adaptation to a low calcium intake however, appears to take a long period of time for persons accustomed to a high calcium diet.

Most of 26 Norwegian men, studied over a four-year period on an intake of 0.45 grams of calcium per day, were able to achieve calcium balance on this intake after a period of time. This was not true of all the subjects however. Calcium retention did not seem to relate to body size or age; in two cases, emotional factors appeared to affect calcium balance[5].

Several decades ago, it was a widely held belief that a high intake of calcium throughout life would improve health and vitality in adult life. This idea was encouraged by Dr. Sherman's early work with rats. Increased longevity and improved reproductive ability were claimed as a result of increased calcium intake. However, differences in calcium utilization between rats and humans made the interpretation of these results in terms of human adult needs somewhat uncertain.

Many workers argue that there is no real evidence of calcium deficiency in those areas of the world where the food supply provides very limited amounts of the mineral. There is also little conclusive evidence of the advantages or disadvantages of excessive calcium intake. Bone calcium reserves might be expected to provide advantages to women during child-bearing years. Adult osteomalacia, linked with pregnancy and lactation in certain Far Eastern countries, is said to respond to vitamin D rather than to calcium

therapy[9]. Osteoporosis, as it occurs in the aged, is generally attributed to faulty bone metabolism rather than to dietary calcium deficiency. After examination of research findings to date, the U.S. Food and Nutrition Board concludes that "adaptation to wide ranges of calcium intake is possible without manifestation of observable effects" and that "ingestion of excessive calcium in foods has not been shown to be, nor is seriously considered to be, harmful."

In a *Suggested Guide to Interpretation of Nutrient Intake Data*[4], the Interdepartmental Committee on Nutrition for National Defence (U.S.) suggests the following rating of calcium intake in grams per day, in terms of a 25-year-old, 65 kilogram (143 lb.) male:

Below 0.3	— deficient
0.30 to 0.39	— low
0.40 to 0.8	— acceptable
Above 0.8	— high

This rating considers a fairly broad range of intake as acceptable and acknowledges the difficulty of setting a more precise yardstick for recommended adult intake on the basis of available evidence.

Conclusion

Many dietary surveys in Canada and the U.S. report a lower consumption of calcium than the recommended standards. This is particularly true of adolescents and pregnant women whose high needs are undisputed. The estimated average supply of calcium in food apparently consumed by Canadians per person per day in 1956 was 1.057 grams[8]. This figure applies to food distributed at the retail level, but makes no allowance for wastage in stores and households or losses in cooking. Calcium is not widely dispersed in foods. Eighty per cent of the total calcium intake comes from dairy products, i.e., milk and cheese. Very small amounts are contributed by dried fruits, green leafy vegetables and legumes. Somewhat larger amounts are available in salmon, including bones, and sardines, and the leaves of broccoli. A diet in which milk and cheese are lacking or are in low supply, is very unlikely to contain even maintenance adult requirement for this mineral.

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The mothers of Norfolk believe that there is no better place than home in which to have a baby. Above 60 per cent of them are delivered at home. In no other country is there such a large proportion of deliveries at home; also there was only one death in Norfolk in 1958 which was due to pregnancy, delivery or abortion.

— Nursing Times, April, 1960

Paint the bottoms of metal cans such as contain baking powder etc., with nail polish to prevent rusting.

— *Alumnae News,* Hotel Dieu of St. Joseph, Windsor.

* * *

All men have a reason, but not all men can give a reason. — CARDINAL NEWMAN

A CAPRICIOUS APPETITE

MARY GOODFELLOW GROOME

How can nurses in the community help mothers solve difficult infant feeding problems?

IT WAS THE SORT OF sunny spring day that finds one out in the garden looking for the first sign of new life. On this particular day, however, excitement came unexpectedly from another quarter. A great moving van was drawn up at the bungalow next door and, amid the bustle of activity, I caught my first glimpse of my new neighbor. Little did I realize at the time that for many weeks there would be only very occasional glimpses!

It was not long before we became acquainted with Mr. and Mrs. Apostolidis, their busy four-year-old John and eleven-month-old Peter. John amazed us by his ability to slip from English to French to Turkish or Greek, all in the course of a single conversation. This, we learned, was because Mr. Apostolidis, a construction engineer, was Greek and his wife, a former school teacher, was Turkish. Both were also fluent in English and French so John was having a wonderful time growing up with a good vocabulary in all four languages.

In every conversation, Mrs. Apostolidis made reference to the baby's "capricious appetite." One evening, when Mr. Apostolidis and my husband were chatting on the patio, I invited him to bring his wife over for coffee with us. He replied that they could not go visiting together until the baby was older, as each feeding required about two hours. This, with her other housework, left his wife with very little time for any social life.

Meanwhile, John was finding it difficult to settle into his new surroundings. In order to attract attention, he became a local "Dennis the Menace." To enable Mrs. Apostolidis to keep an eye on him, he was recruited to amuse the baby during mealtime. It was soon after this that he was found watering the baby with the garden hose!

Peter's feeding problems thus influenced the life of the entire family and, to some extent, reached out into the community. He never experienced the satisfaction of a good meal, and very often suffered the wrath of his older brother. He had not learned to feed himself; had no variety in diet, and had the uncomfortable feeling of attention wrongly acquired.

The extra work involved left the mother tired and listless by the end of the day. Thus, the parents were deprived of each other's company and missed the opportunity to mix with other adults. The community lost the opportunity of learning about other countries, sharing new ideas. We also had to bear the brunt of the four-year-old's frustrations. Not only was John no longer the center of attraction in the home, he actually received very little attention of any kind. He had to fend for himself in a strange environment, without the support that a mother can give a small boy by just being on hand. His rebellion and subsequent punishment only led to greater rebellion.

Peter's Problems

I was curious about Peter and his eating habits. One day the opportunity presented itself, and I asked Mrs. Apostolidis about him.

Peter was born in Canada. He was bottle fed. His mother learned that solid foods were started very early in Canada so she followed instructions and started giving him cereal when the baby was ten weeks old. Peter objected from the beginning. Although he had taken the bottle well, he was not interested in solids. Mrs. Apostolidis soon found herself offering him something to eat whenever he was awake. Peter responded to this by turning

Mrs. Groome, a graduate of Montreal General Hospital, assists a prominent Montreal pediatrician in the program of teaching parents — mainly the mothers — how to care for their infants and children.

away from the spoon and ultimately, making a struggle before accepting even the bottle.

By the age of seven months, he had developed what his mother termed a "capricious appetite." I asked her what she meant by this. She explained by saying that Peter would eat well when he was hungry. He always accepted breakfast readily — cereal, an egg, and eight ounces of milk. (I can almost imagine him thinking, "No sense fussing right now. I'm too darned hungry!")

At nine months of age, Peter "caught a cold," had a low fever for two weeks, loose bowel movements, lost weight, refused all solids and, finally, after refusing liquids, was hospitalized.

Urinalysis indicated the presence of pus. With adequate treatment, he improved rapidly. Soon he took liquids but continued to refuse solids.

After telling the nurses about his prolonged mealtimes, the games to distract him, and the preparation of his favorite food, the mother offered to go to the hospital to feed him. This assistance was refused. Actually, while visiting him she noticed that his meals were usually finished in 20-30 minutes, and also that a variety of foods was taken. During the last few days in hospital Peter even took solids well.

In view of Peter's current behavior, I asked Mrs. Apostolidis what had happened when he was taken home. She smiled and replied that he must have been very hungry because for the next two or three weeks he ate almost every food that was offered without any fuss. Later, as he was coaxed to take more and to eat more often, his capricious appetite returned. At present the day seems to be one continuous mealtime!

Feeding Infants

This pediatric problem of faulty eating habits is a common one. It is one of the early attention-getting techniques used by a baby. It is one of the most difficult problems young parents have to solve. There are three main reasons for this:

Lack of systematic preparatory child care education for all adults.

Pressure of constantly changing trends in present-day child care methods. Differences in these trends are amplified by cultural, language and religious backgrounds.

The apparent lack of time available to the pediatrician to explain satisfactory procedures, even though the time this would take would be much shorter than that needed to correct the problem once it has occurred.

Feeding schedules provide only the framework within which the individual child's nutrition is planned. Time must be taken to explain the schedule to the parents; how it may be varied; how the child may react; how the parents should react. In short, parents should be warned to anticipate feeding problems, to recognize danger signals. They need to be equipped with the necessary knowledge to combat a problem at its inception.

The opportunity to effect a permanent improvement in Peter's eating habits was missed following his stay in hospital, primarily because, during that time, the acute illness and its treatment overshadowed the (then) lesser problem. Secondly, under pressure of a busy routine, the nurses overlooked two of the basic tenets of our profession: in order to give total care, we must know our patient; each procedure must be explained to and understood by the patient. In the case of a small child, we must know and give the explanations to the parents.

We note that while in hospital Peter's mealtime was limited to 20-30 minutes; his favorite foods were not always served; he had to accustom himself to a variety of new foods; there were no mealtime games, and no between-meal feedings. Given a detailed explanation at this time, Peter's mother could have continued the routine at home, and thus avoided what ultimately developed into a major problem.

It was at this stage that we met Mr. and Mrs. Apostolidis. They were pleased to find someone interested in Peter, and in them. After one or two conversations, the mother was asked to recall the five main points she had noticed at the hospital: shorter meal time; no mealtime games; variety of foods; no between-meal snacks; and meals served at a regular time, in a very matter-of-fact way. Their attention was then drawn to the results

that had been obtained by this regime — a hungry Peter enthusiastically eating his meals. We discussed the reasons for the hospital routine and the results. Mr. Apostolidis was the first to agree that when Peter came home from the hospital his eating habits were much improved, and were preferable to the present ones.

It was pointed out that the present problem would not be resolved quickly. It was suggested that the first step should be a thorough examination by Peter's pediatrician. This examination assured the parents that Peter's health and physical development were normal, and that they could confidently embark upon a feeding routine similar to that used in the hospital.

As soon as the parents understood the reasons for the hospital routine, and Mrs. Apostolidis knew what Peter's requirements were and what he could manage, the following suggestions were made:

> Give him small, colorful servings, with new foods introduced at the *beginning of the meal.*
>
> Protect herself and the floor, and allow Peter to *finger feed.* After months of eating soft foods, a "lump" on the end of a spoon can be quite a surprise, but it is a different matter if little fingers explore it first!
>
> Keep in mind that babies are people, and no two people have the same likes and dislikes. We are not always hungry. Some days only two meals may suffice. We don't all like spinach. On hot days we may want orange sections instead of cereal. One day we may loathe asparagus, yet a month later we can't get enough of it! In these respects, baby is just like us!!
>
> Remember that the parents, as well as John and Peter, will benefit from the additional time they will have to enjoy each other's company, and that the community will benefit from the exchange of ideas with these new Canadians.

Much to everyone's satisfaction, Peter's new routine is beginning to show results. Mr. and Mrs. Apostolidis plan to attend together a neighborhood outing scheduled for a forthcoming holiday weekend.

THE RELUCTANT PATIENT

ELEANOR ROBINSON

The diabetic person who accepts his condition and conforms to its limitations intelligently can have a happy, comparatively normal existence. Failure to do so may result in tragedy.

History — Past and Present

WILLIAM MARTIN, AGED 26, was admitted with a provisional diagnosis of diabetic hypertension.

Although diabetes mellitus is considered to be an inherited disease, there was no family history of diabetes in this instance. We are told, however, that a predisposition to diabetes seems to be inherited as a recessive characteristic. It has been estimated that approximately one out of every four persons is a "diabetic carrier." This may have been the case with Mr. Martin.

Miss Robinson is a student nurse at St. Boniface Hospital School of Nursing, St. Boniface, Man.

He had been a diabetic since he was four years old and had spent considerable time in hospital. His present history and a physical examination revealed many complications resulting from the patient's neglect. He did not follow his diet. He tested his urine "once in a while," and took insulin "whenever he felt like it." He said he had a "good appetite" and it was concluded from his conversation that he ate what he pleased, despite his wife's attempts to encourage him to keep to his diet. He had no complaints of epigastric distress, nocturia or dysuria, dyspnea or chest pains. He was very pale with a yellowish tinge to his skin.

For the past three years he had been hypertensive. His blood pressure

was 270/120 upon admission and ranged from 174/85 to 242/140 during hospitalization. His eyesight was poor and was becoming worse gradually. Pitting edema was present, especially at the ankles. This was his chief reason for seeking medical aid. These symptoms indicated renal involvement. As a result of his condition, he was an extremely anxious and apprehensive individual. Prior to admission he had been taking three and one-half tablets of an oral hypoglycemic agent daily. This was changed to 36 units of insulin.

An x-ray disclosed that his heart was slightly enlarged. Hematological studies showed a decreased hemoglobin — 62% — that helped to account for his pallor and an increased sedimentation rate and white blood cell count that confirmed kidney involvement.

Blood sugar readings indicated a wide variation, from 55 mg. % on admission to 393 mg. %. The normal blood sugar is 80-120 mg. %.

On the evening following his admission, Mr. Martin was found in hypoglycemic shock and given intravenous glucose. Bilateral basal rales were heard and pulmonary edema was obviously progressing. An immediate electrocardiogram was done and indicated some abnormality. A chest x-ray showed "mottled changes over central portions of both lung fields consistent with pulmonary congestion and early pulmonary edema." A later report showed normal lung fields.

Rehabilitation

The rehabilitation program for this patient was very extensive although he was not a new diabetic. The aim of therapy in diabetes mellitus should be to maintain health, happiness, and as normal a pattern of nutrition as possible, while keeping the patient's urine approximately sugar-free. In managing this condition, two principles are of the greatest importance: the establishment of a dietary regimen, with or without insulin, and the education of the patient.

Treatment of Mr. Martin's immediate state was medical. It consisted of drug therapy, psychiatric consultation, social service consultation, dietary and insulin control. It was felt that psychiatric help was needed and a consultation was arranged. Mr. Martin admitted that he had tried to commit suicide some time previously by closing the garage doors and leaving the car running. Since no other attempts were confessed, it was felt that intensive psychiatric treatment was unnecessary although he would require sympathetic and understanding support. Eye specialists were consulted about his vision. Unfortunately, they felt that his sight would gradually deteriorate. The hospital social worker contacted the Canadian National Institute for the Blind asking for assistance. The patient was a music teacher and his failing vision made it impossible for him to continue this occupation.

Upon admission a 2000 calorie diabetic diet was ordered in coordination with 22 units of NPH insulin and 16 units of crystalline zinc insulin daily before breakfast. "The diabetic diet is emphatically a quantitative diet and this principle implies accurate control of the intake of food."

This fact had to be stressed emphatically since Mr. Martin often refused meals, or part of them, and asked for foods such as milk shakes and "banana splits" which he could not have. When questioned about his diet, he could explain the principles quite satisfactorily and he appeared to understand the "do's" and "don'ts." Nevertheless he refused to follow his diet even in the hospital. How closely he would follow it at home was very questionable! As long as he was in the hospital he had regular urine tests, but he admitted that he neglected this at home. He required continual supervision and encouragement as he appeared to have despondent moments when he deliberately neglected his health. Usually, he was very cooperative but he seemed to lack the initiative to care for himself without constant urging.

In spite of encouragement and close observation of his food intake, Mr. Martin continued to have a very high blood sugar. Finally it was decided to change his diet to 2000 calories and *low protein*. He was permitted greater freedom of choice of food within these limits. His insulin intake was regulated according to the percentage of sugar in his urine.

He had been faced with the prob-

lems of diabetes since early life but the complications that appeared later required many adjustments. He had to be taught how to live as a blind person. He had to learn how to face his future cheerfully. He had already received intensive instruction concerning personal hygiene, administration of insulin, care of injection equipment, urine testing, insulin reaction, and infection. His refusal to apply his knowledge constituted a major problem. The nurse's chief task was to persuade him to accept his condition, to apply his knowledge intelligently and to take a more optimistic view of the future.

CONCEPTS OF NURSING

FLORENCE E. ELLIOTT

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the second of a series of three articles on this topic.

RECENTLY A STATEMENT was made to the effect that nursing has been undergoing a social revolution. It is doubtful whether anyone familiar with the changes that have come about in the practice of nursing since World War II would seriously disagree. To those of us whose nursing careers antedate that point in history and who have been active in nursing throughout this period, the speed with which we have had to alter our preconceptions has often been dizzyingly rapid, certainly transcending that of evolution.

A nurse who had duplicated Rip Van Winkle's withdrawal from society for the last two decades would return to find nursing very different. Nurses who take up active duty after a number of years devoted to homemaking often approximate Rip Van Winkle's unawareness of what has been happening in their profession in the interim. New techniques and treatments are myriad. A whole new vocabulary seems to have developed. Empathy, acceptance, nursing problems, supportive care, nurse-patient interaction — such terms are used with a high degree of frequency. To the uninitiated they seem strange and only partially comprehensible, if, indeed, they are understood at all. Many of us who have come to see them as useful and meaningful terms may have only a limited conception of their full meaning and application.

Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

The Scope of Nursing

The functions of nursing are rooted firmly in the ministering, comforting skills. These ministrations in the words of Frances Kreuter

> distinguish nursing care from the care of any other helping profession, the doing for a person that which he would do for himself but is unable to do, either temporarily or for a long period of time.

In the early days of nursing the functions of ministering to and comforting the patient constituted the bulk of nursing care. Nurses became so skilled in this area that nursing was considered as an art. However, nursing was not restricted for long to the performance of the simple acts of keeping the patient clean and comfortable. Such skills could be acquired easily under the tutelage of one already skilled. As medical treatment progressed, and as nursing demonstrated its value in the care of the patient, functions of a highly technical nature were allocated to nursing. These functions required new skills and a whole new body of scientific knowledge. The necesssary knowledge and skills could not be acquired other than through some form of organized instruction. The emphasis

on science and technology was great. Such a premium was placed on expertness in the performance of highly technical skills that the stereotype of the efficient, highly starched and impersonal nurse to some extent replaced that of the gentle person who "soothed the fevered brow and smoothed the wrinkled linen." As medicine and nursing progressed, the scope of nursing broadened. There was recognition that people's health needs are not restricted to periods of acute illness. Programs for the prevention of disease and promotion of health were developed. In them nursing found a role. Gradually the concept of hospital care broadened to include responsibility for continuity of care following hospitalization. Nursing extended its service beyond the hospital to the individual and his family in the community.

At the beginning of World War II, nursing was functioning on a very technical basis. Nurses were highly skilled in applying scientific principles as they carried out the therapeutic regime ordered by the doctor. Skilled efficiency in organizing and managing the workload and the patient was the order of the day. There was much verbalization about the importance of the patient. In many places the old routinized procedures were being questioned, if not discarded. Nevertheless, while the patient may have been pampered in some things, many discrepancies between the intellectual acceptance of this patient-centered concept and actual practice were quite evident. The work of the unit was still rushed so that the ward could exhibit a "spit and polish" front for the doctor, even though the patient might have wished to rest a little. The doctor often selected the mealtime for an unpleasant or painful procedure. The patient in a medical center connected with a medical school was often subjected to long clinical discussions of his condition, treatment and prognosis. The doctor prescribed the regime. The nurse carried it out. The patient's role was to accept the prescribed therapy. Public health nursing, by comparison, had made much greater strides toward true patient-centered care. The patient was considered as a member of a family unit as well as a member of society. By and large, for the staff nurse and the private nurse, nursing began and ended with the sickroom. Attention was focused primarily on disease and its treatment.

Nursing that is limited to caring for a patient by giving treatments and medications and making him comfortable may be as narrow and outdated as that viewpoint which sees the world as the centre of the universe without any thought for what we may find in outer space. Many individuals find it easier to remain caught up in consideration of worldly problems than to broaden their knowledge and to hypothesize and plan for the future in a space age. In the same way many nurses find it difficult to stretch their sights to encompass the potential for the scope of nursing that has been presaged by developments during the past two decades. This is understandable, but it is a luxury that leaders in nursing can ill afford.

The Results of Revolution

The acute shortage of prepared nursing personnel has resulted in the addition of more and more nonprofessional personnel to the nursing staff. It has brought about the assignment of tasks to the nonprofessional that were previously within the domain of the graduate nurse. New concepts of medical care have demonstrated that long periods of patient dependency upon the nurse may be harmful or even dangerous. Early ambulation and encouragement of the patient to do for himself has become a part of the accepted pattern of care. The constantly increasing number of medications, many of which must be given by injection, together with more complex treatments, have added to the technical functions assigned to the nurse. Inexorably, and perhaps inevitably, the graduate nurse has moved away from the patient. The functions that once seemed unique to nursing are delegated to workers with considerably less knowledge and skills with increasing frequency.

In her article, "A Philosophy of Nursing," Dorothy Johnson points out that, as a profession, our concepts are blurred. She discusses what can be described as the schizophrenic state in which nursing finds itself today. Some see the professional nurse of the future

operating largely in a supervisory and managerial capacity. She will need nursing knowledge and skills, but in addition she will require the skills of leadership in order to direct others in the care of patients. Some believe just as firmly that the professional nurse can and will maintain, as her primary role the provision of direct care to patients.

It is not possible to predict what the outcome will be. There is much to support both viewpoints. It is even possible that the answer is that we will have both: individuals with much nursing skill and a high degree of managerial skill and, in addition, highly skilled specialists in nursing who expect to, and are permitted to, concentrate their efforts on giving a quality of care that is, perhaps, only a dream today.

Nursing Philosophy

In any setting in which nursing is practised, the quality of nursing is governed to a large extent by the philosophy of nursing that prevails in the setting. If medical practice is chiefly curative; if the nursing staff has limited experience and preparation; if there is a climate which accepts the *status quo,* the philosophy of nursing can be expected to differ sharply from that of a setting which is rich in resources; where medical practice is focused on achieving optimum rehabilitation; where an alert well-informed staff, and intelligent leadership create a climate that stimulates intellectual curiosity. The philosophy of nursing that the individual nurse professes may vary in some details. A careful analysis of nursing as it is practised will identify the prevailing philosophy. The quality of medical practice; the value system of the administration; the intellectual climate; the leadership provided; the experience and preparation of the nursing personnel; and the very concrete factor of economics which determines the number and qualifications of personnel, equipment, supplies and workload, all combine to fashion the philosophy of nursing. The quality of nursing practised may not be of the calibre for which the nurse was prepared. At first her concepts may differ markedly from those which she finds in operation. If she remains for a long enough period, her philosophy can be expected to change gradually to one that more closely approximates that which prevails in the setting.

The philosophy of nursing and of nursing education that prevails in a school and in the areas where students have their clinical experience, govern the experiences that are provided and the learning that results. Too often our philosophy of nursing has developed almost without awareness. Like Topsy, it has "just growed." However, in any school of nursing and in any nursing department in which students have experience, it is vital that the philosophy of nursing be clearly stated and understood by all.

What is Nursing?

In considering curriculum we need, first of all, to examine our underlying beliefs about nursing.

1. Nursing is a service that is performed for individuals, families and groups. It is a service performed for the general welfare of all and as such, may be considered a *social* service.

2. Nursing as a service is practised in homes, hospitals, in clinics, in schools and in industrial settings.

3. As one of the major health services, nursing has a role to play in the promotion of health, the prevention of disease and, where there is illness, restoration to health.

4. The identifying functions of nursing are its ministrations, those comforting operations that minister to the basic human needs. Bathing, feeding, toileting, dressing, listening activities are the core of nursing practice.

5. Nursing complements the activities of the other helping professions. It is unique among them, not only in the highly personalized character of its activities, but also in the continuity with which it provides its services. In the hospital, nursing serves the patient around the clock. It follows him into his home, his school, his place of business. Due to the continuous and highly personalized nature of its service, nursing is in a position to identify many patient needs, physical and emotional, that are not readily discernible to other disciplines. Nursing assumes the responsibility for recognizing these needs and for seeing that they are met. Some lie within the scope of nursing. Some require the

services of other disciplines. Thus, while one aspect of nursing is carried on under the direction of the physician, nursing also has the potential for being a contributing member of the health team rather than a second class member.

6. Nursing varies widely in degree and kind. It may be simple and elementary in nature. If it is largely custodial, palliative or for general maintenance, it can be carried on by almost anyone with a minimum of instruction or experience. It may be no more complex than the care that any wife or mother can give her family. It may be highly technical, requiring skill in many and complex nursing operations. This technical skill is based on broad knowledge of scientific principles and their application. It may be "patient-oriented," in which the method and timing of carrying out the technical operations are governed by nursing judgments. These judgments are based on *nursing diagnoses* that assess the patient's physical and emotional condition. They utilize the nurse-patient relationship in the interests of the well-being of the patient.

7. The skills of nursing derive from a great body of knowledge. This knowledge can be said to have two major components: that which is related to the body and its physical functioning and that which is related to the person and his behavior. There is, of course, a high degree of interrelatedness. In general, from the former we derive the nursing skills that are largely physical and from the latter, those understandings of human behavior which determine in large measure the effectiveness of our ministrations.

What constitutes quality in nursing? Again, let me share my ideas of good nursing care.

1. Good nursing begins with the establishment of a nurse-patient relationship that accords to the patient a status of worth as an individual, whatever his background or behavior. It communicates to him a warm and friendly concern for his well-being; a genuine interest in him as a person; a feeling of concern for his present state. It says to him, "I like you. I understand your problems. I want to help you."

2. Good nursing recognizes that a degree of dependency inevitably accompanies the early stages of illness. It seeks to communicate to the patient a willingness and ability to assume responsibility for his welfare during this time. The nurse's manner and conversation are designed to say "I am here, I have the skills and knowledge to help you. You may depend on me." At the same time, it recognizes that this dependency should be a temporary thing. It encourages progression to independency in the knowledge that this may be a major contributory factor in the return to optimum functioning.

3. Good nursing care means acceptance of the patient as he is. This acceptance transcends the narrower bounds of tolerance and is based on the concept that behavior is meaningful and has cause. Clues to an understanding of individual behavior are sought. Meaning and cause can be hypothesized from what is known of the individual's socio-economic group, his cultural group, his age group; and from what the patient and his family communicate about his past experience.

4. Good nursing care permits the patient to express his feelings without levelling any judgment on the appropriateness of this.

5. Good nursing utilizes problem-solving techniques. It observes. It analyzes what is seen and heard. It identifies the implications for nursing care. It decides on a plan of action. It implements the plan and later evaluates the effectiveness of the action, noting how it might have been more effective. This observation is used in planning a course of action in similar situations.

6. Good nursing recognizes that the patient is a person under stress. He is threatened by his illness and the possible economic consequences. Good nursing recognizes that illness is a period of tension and seeks to relieve it.

What is the relationship of nursing to the treatment prescribed by the doctor? The plan of care which the nurse devises for her patient has two major components:

1. The therapeutic regime prescribed by the doctor.

2. The nursing regime determined by the nurse (those personalized functions which are the specific field of nursing).

It is the task of nursing to fuse these two components into a well-coordinated whole that can be carried out with maximum effectiveness. The nurse has

the scientific knowledge that will enable her to become technically competent in performing the nursing operations which are dictated by the situation, whether they are simple hygienic measures or highly complicated therapeutic procedures.

A Third Dimension

There is also a third dimension for nursing. It derives from the fact that the techniques are used by and with human beings. This brings into play all of the complications inherent in any situation in which more than one individual is involved. Just as the nurse turns to the biological and natural sciences for the principles to apply in developing safe and effective procedures, she must now turn to the behavioral sciences for the understanding of human behavior — her own and the patient's. This will enable her to utilize, more effectively, her technical skill and knowledge on behalf of the patient.

During this century, the behavior of man has been the object of extensive study. Research efforts have been intensified during the past two decades. The result has been a vast accumulation of knowledge which can be of extreme value to nursing. Today nursing turns to the behavioral sciences — anthropology, sociology, psychology and the related field of psychiatry — for the knowledge to use in developing skills and techniques which will enable the nurse to utilize the nurse-patient relationship constructively for the optimum welfare of the patient.

The nurse sees that the basis for developing skill in understanding others is to understand herself. She learns to ask why? Why did I choose a career that involves dealing with people needing help? How do I really feel about people in general? About the aged? About people of other nationalities, of other racial and religious groups, of socio-economic groups different from my own? What are my needs in working with people? Do I need to be needed? Do I need to be an authority? How do I react under stress? To hostility? To warmth and friendliness? To rejection? What may be the effect of my reaction on patients? What is my value system? How does it affect my actions? What do I communicate to others? Respect? Disrespect? Interest? The answers to these questions and many others can form the basis for the development of an effective nurse-patient relationship.

The nurse endeavors to understand the ways in which people react. How do they react to stress, to the unknown, to removal from the family group? What are the ways in which fear, loneliness, tension and anxiety manifest themselves? What does behavior, such as weeping, passive acceptance, demanding, mean? How can we deal with this? When can we permit dependency? When should we discourage it? Do we always obey the doctor's orders to the letter of the law? Do we sometimes bend them a little in the interests of the patient's welfare?

These represent my ideas, my beliefs about nursing, my personal nursing philosophy.

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We cannot always oblige, but we can always speak obligingly. — VOLTAIRE



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Post Convention Tour

GLOWING REPORTS HAVE been coming to National Office from members who were fortunate enough to have gone on the CNA Post Convention Tour.

Twenty-eight nurses made the trip. Leaving Halifax immediately after the convention, the plane landed at Prestwick, Scotland. From there, some of the group visited ancestral homes. Then on to Edinburgh and London where the program for the group, with visits to the Royal College of Nursing and famous health centres and hospitals, made the professional aspect of the tour very worthwhile. The reception given by British nurses was heartwarming. The number of luncheons and teas that were arranged was unexpected but greatly appreciated. The group met most of the officers of the British nursing associations.

From London, the tour visited Paris and the hospital Foch with its school of nursing at Suresnes near Versailles. To us Canadians, who think of the Old Country as not keeping up, a ride on the Mistral train from Paris to Nice clipping along at 70 m.p.h. tends to alter our thinking!

The tour then took the group to the Cote d'Azur on the Riviera, through Rome, Milan and Florence, and a visit to the buried city of Pompeii.

While in Germany the whole group attended the Passion Play at Oberammergau. This play lasted the whole day and was one of the most impressive things many of the group thought they had ever seen. It was an outstanding production and worthy of all the praise it receives. Following this a boat trip on the Rhine — a leisurely sight-seeing day when everyone relaxed and enjoyed the beautiful Rhineland.

In Geneva the group visited the International Committee of the Red Cross, the League of Red Cross Societies and the headquarters of the World Health Organization in the Palais des Nations.

Plane, bus and train transportation provided speed, variety, and opportunities for side trips and visits to unique and historical places of interest. The cuisine was good. Every report indicates that a good time was had by all.

Association Activities

From September 5 to 10, Miss M. PEARL STIVER, the General Secretary-Treasurer, attended the ICN Exchange of Nursing Committee meeting held in London, England.

The past president, Miss ALICE GIRARD, attended the American Hospital Association convention which was held in San Francisco in September.

The National Committee chairmen met with the President at National Office in September to review committee functions and to receive suggestions for appointment of additional members to each committee, as provided in the By-Laws. The proposed activities for the present biennium were studied in the light of the available budget allocation to each committee.

Each committee will hold a full meeting to initiate projects. The subcommittees, consisting of members living in the vicinity of the chairman, will meet regularly to carry on the work throughout the biennium.

The major concern for the Committees on Nursing Service and Nursing Education will be the implementation of the first two recommendations of the Pilot Project report. The As-



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sociation will initiate a study of the whole field of nursing education in Canada and, at the same time, conduct a school improvement program. A study of the nursing services where the students receive their clinical experience is another major project to be undertaken.

13th International Congress on Occupational Health

The development of highly technical, industrialized economies in countries the world over has occasioned various changes in ways of life — where people live, how they live, the services they require. Mechanization has increased production enormously but an efficient machine requires an equally efficient and healthy operator. Quite apart from any humanitarian interest that management feels in the well-being of the workers is the inescapable fact that the man who is healthy physically, emotionally and mentally has greater economic value.

As a direct result, the development of occupational health services is assuming ever-greater importance. The nurse and doctor in the industrial setting are familiar figures but not nearly as familiar or as numerous as needed in relation to the total labor force of any specific country.

Interest in occupational health services is international in character. July 25-29, 1960, the 13th International Congress on Occupational Health was held in New York City. A glance at the list of registrants shows that 43 countries had representatives in attendance. Finland stood proudly at the top of the list as having sent the largest number of delegates in proportion to its size and total number of health workers.

With such a diversity of cultures, simultaneous translation into English, French, German and Spanish was provided for all sessions held in the main meeting room. The compact IBM transistor sets proved most effective. It was quite common to see a delegate, his head-piece firmly clamped into position as he listened to the translator, slipping quietly across the hall to check up on proceedings at the session in an adjoining room.

The range of topics covered was extremely comprehensive. They varied from work physiology and psychology, social medicine, education and training of medical personnel to such specific subjects as industrial poisoning and the role of the pathologist in relation to Workmen's Compensation.

Speakers from Italy, Japan, Canada, the United Kingdom, U.S.A., WHO and the ILO spent a full morning presenting the various aspects of administrative practices in occupational health. Brief mention was made of the part taken by governments; types of health programs; the labor unions in relation to health. The general impression received was the great diversity in ways of handling occupational health matters from one country to another. Health services in Europe ranged from prevention of work hazards to broad protection of the physical, mental and social welfare of the worker. Dr. Sakai, Japan, noted that services in his country varied according to the size of the industry. Mr. James Matthews, an extremely forceful labor leader from the U.K., left no doubt as to the vital role that organized labor can and does play in the protection of the worker. In Great Britain, convictions for violations of the acts relating to labor had, in many instances, been brought about by union vigilance. He acknowledged the responsibility that workers should take for their own welfare. He noted that unions could take a much more active part in educating employees to observe safety measures. The co-chairman for this particular session was Miss Margaret Wheeler, past president of the ANPQ and nursing consultant, Division of Industrial Hygiene, Ministry of Health, Quebec.

In our consideration of Workmen's Compensation, it probably does not occur to us very often to consider the role of the pathologist in deciding claims. This topic provided one of the most interesting sessions of the congress. What the pathologist finds on post mortem examination may have considerable influence in awarding compensation to a family deprived of its breadwinner.

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devoted to the different aspects of health services in industry. Nurse delegates took chief responsibility for the information presented. One speaker discussed the steps necessary in initiating such services in an industry. A requisite is an informed management prepared to give enthusiastic cooperation. It may often fall to the lot of the nurse to "sell" the idea that such a service is in the interests of management. She must be prepared to support her position with sound facts.

The doctor and the nurse in industry are confronted with somewhat unusual problems. The doctor does not have the usual freedom of choice in patient selection. His relationships with his patients are affected by the fact that both doctor and patients have a common employer. The opinion was expressed that the status of the doctor in industry is less satisfactory than that of the nurse. There is a tendency for his confrères to look down upon him because his patients are in the laboring class; because he is somewhat less than his own master. The nurse retains her status but is likely to be subjected to pressures to forego professional norms when they conflict with those of business.

A speaker from the United Kingdom described a successful experiment in setting up an occupational health unit as one of the services of a general hospital. The Central Middlesex Hospital, England serves an area that includes about 1,000 factories. For many employees in industry in this area, it represented the first time that a visiting nurse had appeared in their factory. It required tact, diplomacy and considerable commonsense to win acceptance of the service and achieve effective working relationships.

Finland presented a somewhat different picture. Employment of a nurse by a firm is regarded as an optional social service. Educational programs for nurses in industry are in a state of early development.

Occupational health is one of the developing fields in the nursing and medical professions. While accepted as a necessary facet of policy by many large firms and some smaller ones, much still remains to be done in making the health care of the worker a part of general health services.

J. E. M.

Intergroup Relations in Occupational Health Nursing

CHARLOTTE EPSTEIN, PH.D.

The challenge to the occupational health nurse is probably one of the most interesting in our society today.

Changes in Industry in the U.S.

PROFESSIONAL CONCERN with occupational health is by no means a new thing. McGee[1] notes that the oldest medical literature available describes injuries that may have been sustained in the building of Egyptian pyramids. However, contemporary developments in industry and medicine suggest that this may be the time to extend our definition of industrial medicine.

We have customarily considered industrial medicine as concerned with "the study and control of the inherent and environmental factors affecting the health and well-being of persons at their places of work."[2] We have not, however, generally been aware of the fact that the "environment" of an individual includes the person working next to him. The implication for an extension of the definition of industrial medicine is that the physician and nurse who work in a plant must learn much more about the social-psychological factors involved in human interaction than they presently do in schools of nursing and of medicine.

The United States, with its unique pattern of intergroup relations, presents an interesting case history of the

Miss Epstein is assistant professor of human relations at the University of Pennsylvania, Philadelphia.



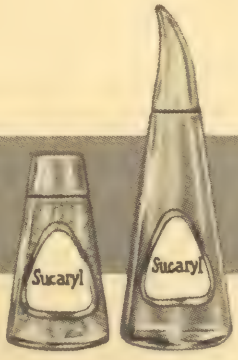
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effects of industrial change on industrial health. Let us look at some of the changes that have occurred in industry recently, and let us see how these changes affect the industrial nurse.

During the last war, the American government inserted in its contracts with private industry a clause which provided that people were to be hired on the basis of skill without discrimination as to race, religion, or national origin. As a result, many industrial workers found themselves working with people who belonged to groups with which they had had little or no contact previously. White workers who were informed that Negro workers were coming into a factory on all jobs were often disturbed at the prospect of employment on an equal basis with Negroes. As in the case of male employees who suddenly find females assigned to the same tasks that they have been doing, white workers were often bothered by the fear of loss of status. They felt that Negroes working as their equals would "pull them down" in their own eyes and in the eyes of their friends. They spoke vaguely of "trouble" that might result from such integration. They frequently threatened to leave their jobs. But in instances where the firm's policy was upheld and workers were told that, though their fears and doubts were understood, the problems would have to be resolved in the course of working with all Americans as equals, production went on as scheduled.

Negro workers coming into plants where Negroes had never worked before often came in with trepidation. They worried about how they would be treated. They did not know what to expect. Often they found that they were quietly insulted, ostracized, and made to feel generally miserable.

But this was by no means the whole story. The fact that the country was engaged in a war against dictorship caused considerable inner conflict between on the one hand, belief in democracy and, on the other hand, the reluctance to give all people an equal opportunity for employment. In addition, the war gave impetus to general fair employment legislation on both state and municipal levels. More and more workers were forced to come face to face with their own prejudices and fears regarding integration. Today, the idea of extending civil and human rights to *all* people is spreading. With it comes the inevitable conflict that accompanies great change in group relationships. In addition to public agencies, a complex network of private agencies has grown up in the United States whose activities are mainly dedicated to alleviating conflict, using it creatively, and helping people to adjust to the shifting group relationships.

All of these changes have resulted in a growing awareness of people for each other across group lines. We no longer take each other for granted. We look about us and wonder about the motives, expectations, and feelings of other human beings. We worry that we "won't know what to say and how to act" when we find ourselves with people of other races or religious beliefs. We are afraid of people with whom we have rarely associated, about whom we really know very little, and of whom we have always heard derogatory stories.

Even those factories that have never employed more than one national, racial or religious group must soon come to grips with this situation. Migration into the United States is at an all-time high. New people are coming into most industrial areas in very large numbers.

Industrial medicine may have begun out of concern for mechanical safety, proper working temperatures, physical comfort and industrial diseases and injuries. It must rapidly extend its concern to a consideration of how the things that trouble individuals in their relationships with other people affect their health and safety.

Nurse's Role in Industry

Though the component groups in Canada are different from those in the United States, the effectiveness of the occupational health nurse in both countries depends on similar operative factors.

The nurse's role in industry is unique — quite different from the role of the nurse in the hospital. Essentially, the industrial nurse deals with *healthy* people. Occupational diseases and injuries have been reduced to the point where they account for only slightly



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over 10 per cent of working days lost. The healthy person has problems and reactions that are somewhat different from those of the ill person. The behavior of the healthy person must be considered in terms of his home life, his social life, his job satisfaction. He has not been suddenly uprooted from his every-day experiences and deposited in a hospital bed where he is at the mercy of new rulers and unfamiliar routine. He must be approached as a mature individual, in reasonable control of himself, and committed to a certain way of life. The emphasis of the work of the industrial nurse must shift more and more into the area of prevention and psychological prophylaxis.

People who are disturbed for any reason are likely to be less competent on the job. If they dislike, fail to understand or fear the people with whom they work; if they resent the boss; if they are discouraged by the depersonalization of mechanical and repetitive work, they may injure themselves, do injury to others, or just not do the job that should be done. The industrial nurse is in a strategic position to take the lead in helping people solve their problems.

Prevention of illness and accident, and correction of maladjustments require a very broad knowledge of the sociological, psychological, and human relations factors that influence the behavior of people. As a first step in prevention there must be an awareness of the various facets of the many interpersonal relationships in a plant.

Nurse-doctor Relationships

Not all firms have a full-time physician. Smaller industries may have a physician on call only for major injuries. The degree of cooperation between doctor and nurse may vary considerably. Some doctors may require little of the nurse excepting the most routine record-keeping. Others may delegate authority to a degree that makes her wonder if she is violating the law against practising medicine without a licence. The problem is not insoluble. Lines of communication between doctor and nurse are not always clearly defined. In some cases the doctor sets the policy and gives the orders but he does not always sit down and discuss with his nurse, as an equal, their areas of jurisdiction and operation; the areas in which one is able to operate more effectively than the other, where one can do more good than the other.

The Nurse's Role

It should be admitted that, in many areas of industrial health, the nurse is in a better position to work effectively than the doctor — especially if she is a full-time, regular employee. She is always there when she is needed. She never requires a special call or an appointment before she may be consulted. For the well person who is grappling with a problem, the opportunity to confide in the nurse — someone sympathetic, possessing a certain knowledge and authority — is enough to send the worker back to his job feeling considerably relieved and at least temporarily able to keep his mind on his work.

Nor is the nurse confined to her infirmary or her office. She can go out into the plant; see the men and women at their machines and benches; stop for a word here and there; inquire about a cold or a cut finger; and generally make it known that she is available on an informal basis. Workers soon come to accept the fact that they have someone in the plant who is professionally trained to understand their problems, and who presents no financial blocks to consultation. If, in addition, the nurse has been able to build for herself a reputation of impartiality, insofar as taking sides between management and labor is concerned, then there is no limit to the confidence that will be placed in her way by both sides.

It is not a simple matter to develop such a reputation. In her very attempts to make purely professional decisions as to whether or not an employee may safely return to work after an accident or illness, she may come into conflict either with middle management or with the worker. It will require extraordinary tact — and even planned strategy — to convince management that the worker should not return to the job or to convince the worker that he really should.

In her visits to the plant, the occupational health nurse learns more about the people in her charge than any



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other member of the organization. Since knowing your students is a basic prerequisite for effective teaching, the plant nurse who mingles with the workers and keeps a sharp eye open to detect unhealthy attitudes and other problems, can do more effective teaching informally and almost "off-the-cuff," than all the posters, directives, and health-and-safety campaigns put together. For example, repeated public display of impartiality by the nurse can do much to help individuals accept members of different religious and racial groups. At the same time, the nurse can let people know that she understands their fears and doubts about associating with people different from themselves; that she is ready to help them work these fears through. It may be accomplished through discussion and examination of their feelings. Often, it is possible for the nurse to find herself in a group at the time of a coffee break or at lunch. She can be instrumental in starting a discussion about problems that she has seen developing. Nobody knows better than nurses that people talk to nurses, about everything and anything. Talking is an excellent first step in tackling psychological problems. At least it is an opportunity to discover the existence of such problems. They are often hidden and smoldering, ready to erupt at the first sign of change.

The nurse must first overcome her own reluctance to discuss "controversial" problems. There is an idea current in our society that it is better not to discuss race, religion, etc. The basis for this idea seems to be that these subjects are so overlaid with strong emotions, that people are unable to discuss them without becoming violent and unfriendly. There is the additional idea, too, that it is better to keep this potential violence quiet — "let sleeping dogs lie."

It is rather easy to demonstrate the fallacy of both ideas. We are all aware to some extent of what is going on in our country these days. The relationships between the various racial and religious groups are shifting and changing. People are no longer sure of where they stand in the general scheme of things. They welcome the opportunity to discuss their feelings of uncertainty. They are curious to know how other groups feel about the situation. A good discussion leader can keep such a discussion within reasonable emotional bounds and help the group develop the feeling that they are not alone in their uncertainty and fear.

To think that "sleeping dogs" can remain asleep forever is specious. The world is too small today for us to think that any social problem can be avoided indefinitely. It makes much more sense to try to figure out how to cope with a situation before it becomes a crisis. Cool heads are much more likely to look at an advancing problem realistically; to consider how everyone is likely to be affected by it; to plan how to solve it with a minimum of difficulty.

Psychological and Sociological Factors

What are some of the psychological and sociological facts that are particularly pertinent to the work the occupational health nurse is trying to do? Although we may be reluctant to admit that there are different socio-economic groups, the fact remains that people of different financial and social backgrounds *do* demonstrate differences in behavior. Unless these variations are recognized for what they are — as different approaches to life, different values, different tastes — we have a tendency to be shocked, disappointed or repelled when we encounter them. Instead of accepting them as interesting, we tend to feel that they represent an interior form of life.

Language is a form of behavior that varies rather obviously from social class to social class. Often it becomes a basis for rejection or suspicion. The direct, frank, voluble, loud expression of the lower socio-economic groups is often erroneously interpreted by people with middle-class modes of expression as threatening and unpleasant. It is reasonable to assume that if we consider a person unpleasant because of his speech, we are less likely to try to understand and to appreciate him. Choice of words and tone quality may constitute an almost impenetrable barrier to understanding and acceptance between individuals of different socio-economic groups.

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different people in different ways. They can often result in walls of ignorance and hostility between groups. When we think of our own lives, we realize how little friendly association most of us have had with people of races, religions, and nationalities different from our own. We have lived among people like ourselves, played with them as children, gone to school and probably to work with them. Where, then, have most of us had the opportunity to get to know people of other races, to understand their problems, and to appreciate their aspirations? As a consequence, we have a tendency to view with suspicion, accept with reluctance, or reject categorically people who appear different from us.

Separation between groups assumes even greater proportions when we realize the differences in experience encountered by minority-group members and members of the dominant group. Minority-group members can not rent or buy homes where they might wish, even when they can afford it. The most respectable, well-educated family is over and over again refused the sale of a home merely because it is a Negro family or a Jewish family.

In education, too, minority-group members often meet rejection and disappointment. Italians are refused admission to medical schools merely because they are Italians; Jews face quota systems in colleges; Negroes are compelled to go far afield because tax-supported, state universities in the area in which they live will not admit them.

In employment situations minority-group members know the story of evasion, delay, and outright refusal of employers to consider them on merit. They know of school guidance counsellors who steer their children away from chosen and desirable careers on the premise that they "won't have a chance in that field." They have experienced year after year of stagnation in menial jobs because upgrading was denied to them.

With such experiences, such memories, minority-group members necessarily become "different." People who have not had such expeiences simply cannot understand or appreciate minority-group feelings and attitudes, unless they make an earnest effort to develop such understanding.

On the other hand, members of the dominant group are also prey to experiences that result in certain attitudes. They hear stories about other races and religions that are too frequently garbled, distorted, and false. These stories are repeated so often and questioned so rarely that they come to be accepted as truth. Unfortunately we are not taught, as a general rule, to doubt, to question and to check all generalizations about other people. It is much easier and more comfortable to accept those generalizations and to act as if they were true.

As a result, dominant-group individuals, when faced with the necessity of associating with minority-group members, often refuse to participate with them in common projects. They react with hostility and antagonism to the thought of such participation. The fear of loss of status is the underlying motive for such reactions. It is similar to the reaction that occurs when women workers come into departments for the first time.

The Occupational Nurse as Educator

The nurse is in a strategic position to utilize all the foregoing facts, since, in her function as health educator, she can appreciate the effects of these psychological and sociological factors on the behavior and attitudes of the people in her charge. She must have a sound understanding of educational principles, and skill in educational techniques, if she is to fulfill her aim of better health on the job. How people learn, why they will or will not learn, and how to teach them to *want* to learn are all problems with which the occupational health nurse must concern herself. She must develop skill in problem-solving and in encouraging free exchange of ideas and expression of opinions. She must be able to teach role-playing and to give discussion leadership in order to help people in their problem-solving efforts. She must be aware of the availability and effectiveness of visual aids. She must be aware of community resources so that she may call on them whenever necessary to supplement her own knowledge and skills.



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Education for Occupational Nursing

This has not been an attempt to cover the vast field of intergroup relations in occupational health nursing exhaustively. It is hoped that the views expressed will indicate the need for more emphasis on this aspect of the profession in schools of nursing. Occupational health nursing is a rapidly expanding field. More adequate preparation is required for the nurses who enter it so that they may deal more effectively with the unique problems that they encounter in their work. Though it is true that all professional people must continue to study and learn while they work, there is no substitute for the basic orientation and systematic preparation that schools can provide. The occupational health nurse is denied this advantage presently.

Knowledge of occupational health should not be reserved only for those nurses who plan to make it their career. In an industrial society such as ours, every nurse should be aware of the effects of work situations on people. The patient who comes to the doctor's office often comes from an industrial job; the patient who leaves the hospital goes back to industry. The nurse who knows nothing about the situation in which her patient functions, is seriously handicapped in her understanding of him as a person.

The job of conserving health through supervision, treatment, and education is a vital and continually expanding concept. It deserves the growing concern and activity of the best prepared and the most enthusiastic people in our society today.

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Learning is essential for a successful life, but it is also a source of much pleasure.

Acquisition of one's language is indispensable, because without language, it is impossible to clearly express and explain one's ideas.

The study of several languages enlarges intellectual horizons and results in better understanding of many things. History, which tells the story of the knowledge and experiences of men down through the centuries, enables gifted men to see the events of contemporary life in their true light; it permits better judgment with a wider perspective. The pupil draws from the study of mathematics and ability to reason quickly, correctly and logically. And the sciences transmit knowledge of nature that man never ceases to accumulate.

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Alice Lilian Wright, who has been the executive secretary of the Registered Nurses' Association of British Columbia since 1943, retired the end of August.



(Hannay)

ALICE WRIGHT

Born and educated in Charlottetown, P.E.I., Miss Wright was in her 'teens when her family moved to Vancouver, B.C. Following her graduation from the school of nursing, Vancouver General Hospital, in 1918, she served as a head nurse there for two years before migrating to the United States to work as so many young nurses do today. Specializing in pediatric nursing, Miss Wright secured her Bachelor of Science degree at Teachers College, Columbia University, then joined the faculty of the pediatrics department at the Columbia-Presbyterian Medical Center in New York. During her years in this field, Miss Wright made an interesting collection of ancient nursing bottles.

The development of districts and chapters, as the framework of the provincial association activity, was in its infancy when Miss Wright assumed her responsibilities with the RNABC. Firmly believing that the expanding membership would be more interested in active participation in the affairs of the association if they knew their secretary personally, she not only took part in chapter organization activities but planned for regular, repeat visits. An ardent photographer, Miss Wright made international and national nursing figures come alive to her audiences as she reported the meetings she had attended.

Nor were her activities limited to British Columbia. Through her quiet leadership, the conference of provincial executive secretaries and registrars has played an increasingly important role in inter-provincial nursing developments. Miss Wright was invited to assist the nurses of New Brunswick in their initial analysis of the nursing needs of that province.

Though she has retired, Miss Wright has every intention of continuing her lively interest in the problems of nursing. A member of the I.C.N. Membership Committee, she plans to attend the Quadrennial Congress in Melbourne next April. She will maintain her residence in Vancouver.



(Sherick)

ELEANOR S. GRAHAM

Succeeding to the post of executive secretary of the RNABC is **Eleanor Scott Graham** who has functioned as assistant since her return to Canada last year after five years of service with World Health Organization as supervisor of nursing for Southeast Asia, with headquarters in New Delhi, India. A British Columbian by birth, Miss Graham engaged in public health nursing following her graduation from Van-



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couver General Hospital and the University of British Columbia. During her postgraduate study at the University of Chicago, where she secured her Master of Science degree, she specialized in administration. She found the principles equally applicable to her work as one of the assistant directors at the National Office of the Victorian Order of Nurses in Ottawa and as director of nursing at Royal Columbian Hospital, New Westminster, B.C. Miss Graham has travelled the length and breadth of the province during this past year, meeting the nurses in their own environment and developing a broad understanding of their needs and problems.

The Alberta Association of Registered Nurses has appointed **Helen Mary (Garfield) Sabin** as its new executive secretary. Born in British Columbia, Mrs. Sabin came to Alberta at an early age and received much of her basic education and her professional preparation in that province. A graduate of University of Alberta Hospital, Edmonton, she holds her B.Sc. in nursing with a major in public health.



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HELEN SABIN

In the intervening years between graduation and her present appointment, much of her professional life was spent in the public health field in various parts of Alberta. For two years she was nurse in charge of the Social Hygiene Clinic, Calgary, A year as clinical instructor at the University of Alberta Hospital was followed by a year of school nursing in Edmonton.

Off duty she enjoys an outdoor life — curling or hiking as the seasons permit. Apart from this she has devoted considerable time to Girl Guide and Boy Scout groups, teaching St. John Ambulance classes and to participation in various aspects of church work.



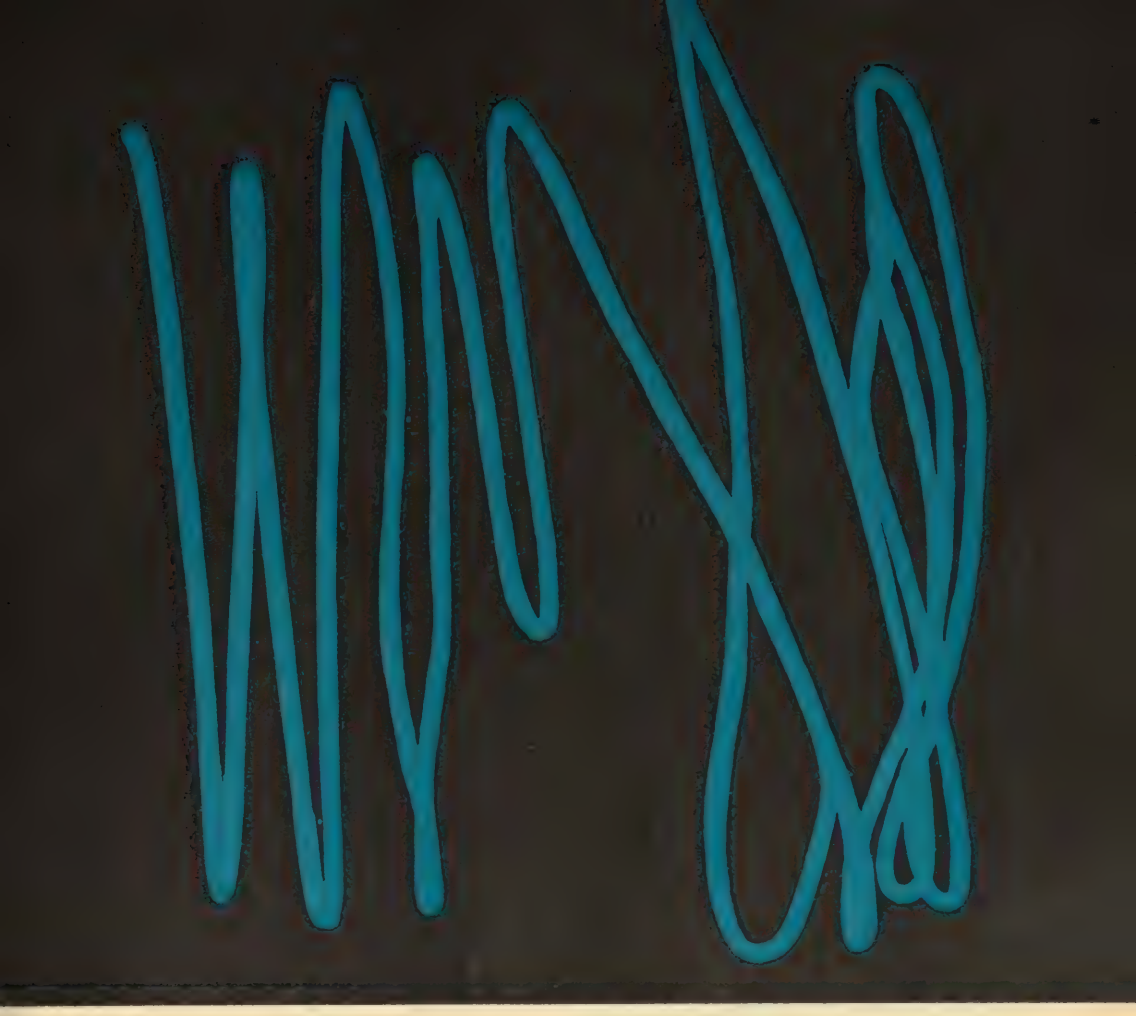
MARJORIE MILLIGAN

Marjorie Kerr Milligan, executive director of Montreal's Child Health Association retired during this past summer. A graduate of Royal Victoria Hospital, Montreal, Miss Milligan studied administration and supervision in schools of nursing at McGill University.

Shortly after her graduation she joined the nursing staff of the Alexandra Hospital, Montreal, first in the capacity of night superintendent and then as a medical follow-up worker. Her first contact with the Child Health Association came in 1928. Beginning as a staff nurse, she was supervisor of CHA's health service division in 1937. In 1943 she became assistant to the executive director, succeeding to the directorship in 1950.

Her retirement from the agency that she has served so faithfully will occasion considerable regret. Good wishes are extended for a satisfying and happy future.

It is always a matter of general pride and pleasure to other members of the profession when one of their number receives signal honor for her professional service. **Edith Davis Kemp,** supervisor of nurses at the Provincial Mental Hospital, Ponoka, Alta,. was named the "Psychiatric Nurse of the Year" in June this year at the Cana-



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dian Mental Health national conference. Miss Kemp is a graduate of P.M.H. and the Royal Alexandra Hospital, Edmonton. In conjunction with this special recognition, she was awarded the Marjorie Hiscott Keep White Cross Medal given in memory of a pioneer in the field of psychiatric nursing. On behalf of friends and colleagues in her profession, we extend warm congratulations.

Ann Beckingham, a 1953 graduate of the Montreal General Hospital, recently undertook what promises to be an exciting new assignment when she joined the American University of Beirut, Lebanon. She is an instructor and supervisor in general nursing at this institution.



ANN BECKINGHAM

Miss Beckingham completed requirements for her Master's degree in nursing service administration shortly before leaving to take up her new position. Her professional career since graduation included night supervisory work, assistant and head nurse experience at the Montreal General Hospital; operating room experience at the Jackson Memorial Hospital, Miami and at St. Luke's Hospital, New York City. Her new duties and, in particular, her new environment will provide her with a wide range of interesting experiences.

Doris Janet (Watson) Seager has been appointed to the professional staff of the AARN provincial office as assistant executive secretary. She began her duties early in July. A graduate of the Winnipeg General Hospital, Mrs. Seager obtained her diploma in teaching and supervision from the University of Manitoba and similar



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DORIS SEAGER

qualification in administration in schools of nursing from McGill School for Graduate Nurses.

She was the science instructor at the Galt School of Nursing, Municipal Hospital, Lethbridge for several years before joining the staff of Aberhart Memorial Sanitorium, Edmonton as clinical instructor. In 1953 she became associate director of nursing service, Royal Alexandra Hospital, Edmonton. For a few months prior to her present appointment she was the northern supervisor for the Junior Red Cross units.

Mrs. Seager has taken an active part in professional activities. She was president of the Edmonton Chapter, AARN, 1957-59. Her off duty interests are varied. She is a member of the Alpine Club of Canada, the Sky Line Trail Hikers' Association and the Altrusa Club of Edmonton.

With the current developments in hospitalization programs, we welcome the appearance of a growing number of nurse consultants to interpret the views of our profession.

Frances Eileen Cole has been appointed to the Northwest Regional Hospital Council of Saskatchewan in the above capacity. A graduate of St. Paul's Hospital, Saskatoon, she obtained her diploma in administration of hospital nursing service from the University of Saskatchewan earlier this year. Since graduation she has served as a head nurse in St. Boniface Hospital and the Department of Veterans' Affairs Hospital, Saskatoon; a clinic nurse at the Saskatoon Cancer Clinic;

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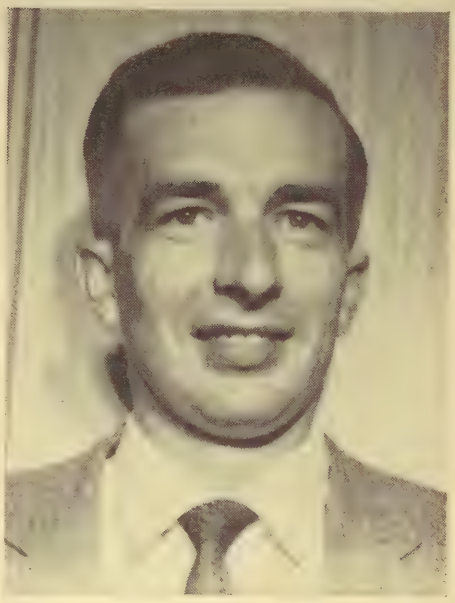
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EILEEN COLE

assistant head nurse, Lethbridge Municipal Hospital, and general duty nurse, Westminster Hospital, London, Ont.

Russel Earl Dagenais was appointed nursing counsellor to the Quill Plains Regional Hospital Council in February, 1960. He is a graduate of St. Elizabeth Hospital, Humboldt, Sask. with a diploma in teaching and supervision from the University of Saskatchewan. Mr. Dagenais was awarded the provincial Department of Public Health bursary for postgraduate preparation. He has had considerable experience in teaching and supervisory capacities since his graduation having served as clinical instructor in the operating room of his hospital for a year and then as classroom instructor and finally clinical instructor in medical nursing.

He has taken an active part in the professional activities of his alumnae association and is the present chairman of the Quill Plains Regional Nursing Council. In the past he served on the executive of the local chapter, SRNA. Off duty he takes an active interest in community affairs.



RUSSEL DAGENAIS

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— Journal of the Louisiana State Medical Society, December, 1959.

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References: (1) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* 82:513, 1960. (2) Editorial Comments: *Canad. M. A. J.* 82:537, 1960. (3) Brownrigg, G. M.: *Canad. M. A. J.* 73:787, 1955. (4) Roy, T. E.; Collins, A. M.; Craig, G., & Duncan, I. B. R.: *Canad. M. A. J.* 77:844, 1957. (5) Royer, A., in Welch, H., & Marti-Ibañez, F: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783.

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Book Reviews

Science Principles Applied to Nursing by Madelyn Titus Nordmark, R.N., B.S., M.S. (N.E.) and Anne W. Rohweder, R.N., B.S., M.N. 276 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 1959. Price $5.00.

Reviewed by Miss Beryl Seeman, Instructor, Grace Hospital, Winnipeg.

This book provides for the nurse-educator a wealth of simply stated facts gleaned from many fields of nursing.

Perhaps its scope, nature and quality may be comprehended from the following notes:

1. The studies upon which it is based were carried on over a period of five years.

2. Over 40 people contributed in one way or another to the compilation of material.

3. The approach to the preparation of the material is significant. In order to identify principles underlying nursing care, hypothetical patients suffering from many different conditions were studied. The total nursing care emphasizing the basic principles was outlined in each instance. The material was categorized to prevent repetition.

4. The manuscript was submitted to persons well versed in the scientific and clinical fields who criticized it before it went into final form.

There is a detailed introduction and a chapter outlining the possible usefulness of the book in nursing education. It could be used to help evaluate the attainment of objectives, as an example.

The main body of material is divided into two parts: principles of natural sciences; principles of social sciences. In the sections dealing with natural sciences, nursing care is outlined first in a brief, tabulated form. This is followed by the principles of anatomy and physiology, physics, and chemistry underlying such care. In dealing with social sciences, concepts are stated first, then the principles that derive from them and finally related nursing measures. One can ascertain a desired fact within a matter of seconds.

This book would be useful primarily for instructors. It could serve as a reference in preparing material in their own particular areas. It would also help them to grasp quickly and in greater detail the relationship of each area of student learning to the whole. The authors have remarked that the time allowed for the studies was limited so that some areas of nursing, such as the giving of medications, have not been covered.

This is a book that is difficult to review adequately. I feel that any nurse-educator would continue to find new values in it even after many months of use.

Professional Nursing by Eugenia K. Spalding, R.N., M.A., D.H.L. 694 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 6th ed. 1959. Price $6.00.

Reviewed by Mrs. Jane E. Mooney, Associate Director of Nursing Education, St. Paul's Hospital, Vancouver, B.C.

The first edition of this excellent book was called *Professional Adjustments in Nursing*. It was designed for use by senior students in schools of nursing offering a basic curriculum, under the guidance of an instructor who was responsible for coordinating their planned experiences. This edition is based upon studies made by the author among graduate and student nurses. These studies were carried out to determine the problems and needs of nurses. The book is intended to help both student and graduate to understand trends and problems in nursing. It is intended also, to serve as a guide to solving some of these problems so that the individual nurse may be able to make good personal and professional adjustments.

The objectives remain unchanged. The text should be of value to the junior student as the first two chapters describe nursing as a profession in its social setting. It could be a valuable addition to the library of a school counsellor as she guides young people in the choice of a profession.

Of particular interest to the more advanced student nurse are chapters five to nine. Various fields of practice open to nurses, the preparation and qualications required, the functions of the nurse, and the advantages and disadvantages of each of these fields are discussed in detail.

New topics, not usually mentioned in similar texts, are problem-solving, national student nurses' associations, minute-taking, and nurses in civil and defense mobilization. Especially well written is a chapter on international nursing organizations. The material concerning personal budgeting should be a great help to the young graduate.

The illustrations, both graphic and photographic, are skilfully used. The problems at the end of each chapter are pertinent. They should stimulate individuals and groups to



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further research and study, and attempts at problem-solving. The reference lists are especially useful because they are classified under important broad headings.

Completely omitted as a topic is leadership — how it may be developed and the responsibility of schools of nursing to develop this quality in their students.

This is an interesting, informative, up-to-date textbook. Though it was not intended as a guide to improve public relationships, it should be valuable in interpreting to allied professions and the general public just what the nursing profession is attempting to do to meet the needs of the public, and what problems we are encountering.



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Supervisor (Evening & Night Service) for 110-bed hospital. Starting salary, 1960: $330; 1961: $357, more if experienced. For information apply giving qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

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PERSONNEL OFFICE, WORLD HEALTH ORGANIZATION,
PALAIS DES NATIONS, GENEVA, SWITZERLAND



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty in modern 40-bed hospital in resort town on beautiful Lake Huron. Starting salary $270, 40-hr. wk., 14 days sick leave, 8 statutory holidays, 4-wks. vacation after 1 year, board & room $30, modern living quarters. Transportation allowance after 1-year service. Apply: Superintendent, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses for 76-bed General Hospital in small town, 16-mi. from Sarnia. Good personnel policies in effect. Limited residence accommodation available. Apply to: Administrator, Charlotte Eleanor Englehart Hospital, Petrolia, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario

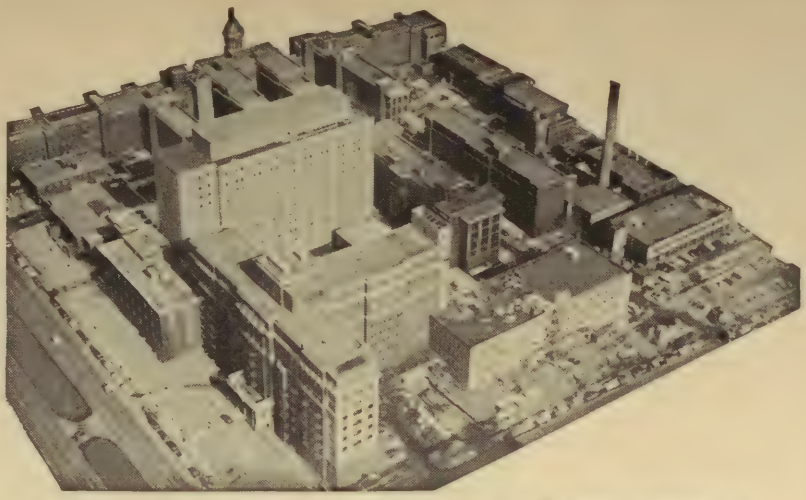
General Duty Nurse Starting salary $270 per mo. **Charge Nurse** salary $300 per mo. for 50-bed hospital, resort area. 5-day wk. Apply: Administratrix, Huntsville District Memorial Hospital, Huntsville,, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.



TORONTO GENERAL HOSPITAL

REQUIRES

Registered Nurses and Certified Nursing Assistants

for Medical and Surgical Services
including newly opened Neurosurgical and Cardiovascular Units

Rewarding Experience — Excellent Personnel Policies

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Director of Nursing, Toronto General Hospital, 101 College Street, Toronto 2, Ontario

REGISTERED NURSES

Enjoy Sun, Surf and Sand the year round in beautiful San Pedro near the Pacific Ocean in Southern California, one-half hour drive from the heart of Los Angeles.

Immediate positions available for General Duty nurses on all services and shifts in Community Hospital. Opening of new modern 140 bed building will create even many more attractive positions in early January, 1961.

Starting salary $345 per month for day shift; $355 for evening and night shift, with $10 additional for surgery and obstetrics. Yearly increases for four years. Liberal personnel policies include cumulative sick leave, seven paid holidays per year, Blue Cross Insurance available, plus two weeks' vacation after one year and three weeks after five years' employment. Contact:

DIRECTOR OF NURSES, SAN PEDRO COMMUNITY HOSPITAL,
1305 W. 6TH STREET, SAN PEDRO, CALIFORNIA

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Staff Nurses & Certified Nursing Assistants for surgical, medical, obstetric & pediatric departments. Comparable personnel policies. Well planned orientation & in-service programs. Apply: Director of Nursing, Toronto East General Hospital, Coxwell at Sammon Ave., Toronto 6, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurses (Qualified) Generalized program includes some bedside nursing. Salary $3,500 - $4,500; annual increment $200, 5-day wk., car provided or car allowance. Apply to: Dr. Charlotte M. Horner, Director, Northumberland-Durham Health Unit, Cobourg, Ontario.

Public Health Nurses with certificate. Benefits include pension, hospital & medical coverage, vacations & statutory holidays. Salary range $3,630 - $4,174 per year plus car allowance.Apply in writing to: Personnel Director, Township of Scarborough, 2001 Eglinton Avenue East, Scarborough, Ontario.

Public Health Nurse (Qualified - Catholic) for St. Elizabeth Visiting Nurses' Assn. Minimum salary: $3,600, annual increment. 5-day wk., 4-wk. vacation. $100 uniform allowance. Pension, P.S.I., Blue Cross. Apply: Director, 67 Bond Street, Toronto, 2, Ontario. EM. 8-1863.

BERMUDA

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Graduate Nurses & Certified Nursing Assistants: Immediate positions available in Medical, Surgical & Obstetrical units. Salaries in accordance with scale recommended by Provincial Nurses' Association. Attractive personnel policies. Apply to: Director of Nursing Service, St. Mary's Hospital, Montreal 26, Quebec.

General Duty Nurses for Obstetrical Service. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

SASKATCHEWAN

Operating Room Supervisor with postgraduate training, for 180-bed hospital. Average monthly surgical load - 157. Basic Salary $335 per mo. Duties consist of administration of department & educational program of students in department. Apply stating qualifications & experience to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Obstetrical Supervisor for 225-bed General Hospital, good personnel policies. For further information contact: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty in Medical & Surgical Wards. Salary $270-$345, good personnel policies & liberal holiday allowance. Apply: Director of Nursing, Providence Hospital, Moose Jaw, Saskatchewan.



Residence, Cook County School of Nursing

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385 for a 37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

OPERATING ROOM NURSES

For expanding 374 bed General Hospital located on Long Island Sound just 45 minutes from New York City.

- Starting salary $355, annual increases for four years.
- $15 bonus paid for each night on call.
- Paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.
- Scholarship aid available for continued collegiate study.

Apply: Operating Room Supervisor

NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Registered General Duty Nurses (2) for modern 7-bed company hospital. Salary $315 per mo., $10 accredited postgraduate courses, overtime paid, $25 increment after 1 year. Full maintenance, transportation paid from point of hire in exchange for 1 year service. Group insurance & attractive vacation benefits. Excellent recreational facilities, boating, fishing, swimming, bowling, etc. Apply: Miss N. Prefontaine, R.N., Matron, Gunnar Mines Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses — You can come to California & make $375 per mo. as a staff nurse. Openings are now available on the Obstetrical, Medical & Surgical Services. If you speak & write English & are eligible for California registration, write us for full details: Evelyn Nina Spees, R.N., Los Angeles County General Hospital, 1200 North State Street, Los Angeles 33, California.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40-hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

Attention! General Duty Nurses 400-bed fully accredited County Hospital located 2 hr. drive from San Francisco, ocean beaches & mountain resorts in modern & progressive city of 35,000. 40-hr. 5-day wk., 3-wk. pd. vacation, paid holidays, pd. sick leave, retirement plan, social security, & insurance plan. Accommodations in nurses' home, meals at reasonable rates, uniforms laundered without charge. Starting salary $341 per mo. plus shift & service differentials. Increase in 6-mo. Must be eligible for California Registration. Write Director of Nursing, Stanislaus County Hospital, 830 Scenic Drive, Modesto, California.

Staff Nurses — San Joaquin General Hospital, a teaching hospital with internes, residents, & school of professional nursing. Positions available on most services on all shifts. Starting salary $376 per mo., differential for evening & nights. Laundry uniforms $5.00 per mo., liberal personnel policies, living facilities for single persons on hospital grounds. Contact: Personnel Director, 732 East Main Street, Stockton, California.

DIRECTOR OF NURSING

The Toronto General Hospital is accepting applications for the position of Director of Nursing.

The Toronto General is a 1450-bed hospital with an enrolment in the School of Nursing of approximately 300.

It is a teaching hospital associated with the University of Toronto.

Applications should be directed to:

THE SUPERINTENDENT
TORONTO GENERAL HOSPITAL,
101 COLLEGE STREET,
TORONTO 2, ONTARIO.

Applications will be considered confidential

ALUMINUM COMPANY OF CANADA, LIMITED

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for medical department, Kitimat Works. Must be eligible for or obtained B.C. registration. Previous experience in industrial plant an asset. Full employee benefits.

Applications may be obtained by writing to:

THE EMPLOYMENT SUPERVISOR,
ALUMINUM COMPANY OF CANADA, LIMITED,
BOX 1800, KITIMAT,
BRITISH COLUMBIA

MONTREAL CHILDREN'S HOSPITAL

invites applications for the position of Assistant Director of Nursing Service

Must hold qualifications for registration in Quebec.

University Degree in Administration preferred, experience in supervision necessary. Salary dependent upon qualifications & experience, Good personnel policies with 4-weeks annual vacation & pension plan.

For further information, address inquiries to:

DIRECTOR OF NURSING
MONTREAL CHILDREN'S HOSPITAL
2300 TUPPER STREET
MONTREAL, QUEBEC

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

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QUEEN MARY VETERANS' HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
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Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg.
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service. Kaiser Foundation Hospital, Oakland 11, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $330 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Good salary, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N's. $58 per wk. Experience considered, differentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101 Hall of Records Building, Fresno 21, California

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General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of Nurses, General Hospital, Tulare, California.

ONTARIO

Director of Nursing for 50-bed hospital in beauty spot of lakes & rivers, cooperative & pleasant staff. 5-day wk., pension plan, salary commensurate with experience. Apply: Administrator, Huntsville District Memorial Hospital, Huntsville, Ontario.

JOSEPH BRANT MEMORIAL HOSPITAL

1240 NORTH SHORE BLVD., BURLINGTON, ONTARIO.

This modern General Hospital will be ready for occupancy in early 1961.

Applications are invited for Supervisory and Staff positions in nursing service.

Opportunities are available for Registered Nurses and Certified Nursing Assistants in pediatrics, obstetrics, medicine, surgery, operating Room, and central supply.

Apply to the

DIRECTOR OF NURSING

SPEECH THERAPIST TRAINEES

Bursaries are available for individuals wishing to enrol in a Diploma Course in Speech Pathology and Audiology and upon graduation to be employed by the Nova Scotia Society for the care of Crippled Children.

Applicants should be graduates of an Approved School of Nursing or should hold a Bachelor's degree, preferably in Education, from a recognized University.

For further information, apply to:

THE EXECUTIVE DIRECTOR
THE NOVA SCOTIA SOCIETY
FOR THE CARE
OF CRIPPLED CHILDREN
P.O. BOX 331, HALIFAX
NOVA SCOTIA

KINGSTON GENERAL HOSPITAL

requires

GENERAL DUTY NURSES

for:

Medical, Surgical Floors
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(male or female Registered Nurses considered for all above positions)

Certified Nursing Assistants

Trained psychiatric attendants (F)

For full details relating to hours, vacations and benefits, apply to:

DIRECTOR OF NURSING,
KINGSTON GENERAL HOSPITAL,
KINGSTON, ONTARIO

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics
by July 15th, 1961.

Qualified applicants are invited to apply.

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

JEWISH GENERAL HOSPITAL
MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Instructor with post basic preparation in Nursing Education required for School of Nursing. Excellent personnel policies. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

BRITISH COLUMBIA

Registered Nurses for modern active 25-bed hospital on beautiful Lake Windermere in the Canadian Rockies. Excellent recreational facilities all yr. 90-mi. from Banff & Lake Louise. Policies according to RNABC. Basic salary: $285 per mo. Excellent residence accommodation with full maintenance: $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

Graduate Nurses (4) immediately for 40-bed hospital. Salary $300 per mo. for B.C. Registered Nurses & $15 less per mo. for non-registered nurses. 3 yearly increments, 40-hr. wk., 1½-days sick leave with pay per mo., 28-days vacation with pay after 1-year of employment & 10 legal days per year. Fare from anywhere in Canada advanced & need not be repaid if you stay 6-months. Superannuation benefits, uniforms are laundered gratis by the hospital. There is a new modern residence which is available for $45 to $50 per month. Interesting social advantages as an excellent Choral Group, excellent educational opportunities and good sporting, Skating, Bowling, Fishing, Boating, Curling, Hunting, etc. Kindly apply giving references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

MANITOBA

Registered Nurses (2) immediately; for 10-bed hospital. Salary $310 with increments every 6-mo. Full maintenance $45, 5-day wk., month vacation with pay following years' service. Apply: Secretary, Benito Hospital, Benito, Manitoba.

General Duty Nurses for Clearwater Lake Hospital, The Pas, Manitoba. Interesting nursing with White, Indian & Eskimo patients both in general & tuberculosis wards. Starting salary $300 per mo. Good accommodation in nurses' residence. 3-wk vacation, 40-hr. wk., 10 statutory holidays, group insurance plan. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 1654 Portage Avenue, Winnipeg, Manitoba.

NOVA SCOTIA

Registered Laboratory Technician. Good personnel policies. Apply stating experience & qualifications, to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

Operating Room Nurse — 40-hr. wk., good starting salary. Apply to: Director of Nurses, Western Kings Memorial Hospital, Berwick, Nova Scotia.

ONTARIO

Director of Nursing for 80-bed General Hospital, 20-mi. from London. New Hospital to be built early in 1961. Excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, or phone collect. Strathroy, Ontario.

General Duty Staff Nurses for 80-bed hospital, 20-mi. from London. Accommodation available in residence, excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, Strathroy, Ontario.

General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time allowance. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

Nurses (2) for United Church Mission Hospital in northern British Columbia. Salary $285 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia. or** Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Avenue East, **Toronto, Ontario.**

P.E.I.

Director of Nursing Education, degree preferred, **Medical-Surgical Clinical Instructor, Nursing Arts Instructor,** for school associated with 200-bed hospital, salary based on qualifications & experience. Apply to: Director of Nursing, Prince Edward Island Hospital, Charlottetown, Prince Edward Island.

QUEBEC

Operating Room Nurses for modern well-equipped department in 140-bed General Hospital, no rotation, but required to take night calls. Good personnel policies & salary in accordance with ANPQ recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

MRS. COWARD'S TRAINED NURSES INSTITUTE

62, St. George's Square, London, S.W.1, England
Founded 1904

VACANCIES ARE AVAILABLE FOR SELECTED STATE REGISTERED NURSES WHO DESIRE TO UNDERTAKE PRIVATE NURSING.

The Institute, established for over 50 years as a non-profit making venture, offers nurses the advantage and comfort of facilities at its premises; also board and residential accommodation at moderate prices.

Full particulars as to remuneration, etc. may be obtained on application to the Sister-in-Charge at the above address.

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Executive Director and Editor: Margaret E. Kerr, M.A., R.N.
Associate Editor: Jean E. MacGregor, B.N., R.N.
Assistant Editors: Gabrielle D. Coté, M.A., R.N., Pamela E. Poole, B.N., R.N.
Production Assistant: Elizabeth M. Hanlon. *Translator:* Lily Tasso
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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
Student nurses — one year, $2.00; three years, $5.00.
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Between Ourselves

Thinking over a suitable introduction to this column this morning, we counted up on our fingers the number of years we have bid farewell to an old year and greeted a new one in this fashion. This is our *seventeenth* Christmas issue! Since the December issue of 1944 there has been such tremendous expansion in nursing activities and in the *Journal* itself, that one is inclined to look back, almost with nostalgia, to the relatively carefree days of a 72-page issue and some six thousand subscribers.

Our work-load and the staff to carry it 17 years ago was similar to that of our CNA National Office and the offices of the provincial nurses' associations. We had one editor and three clerks; National Office one general secretary and two clerks. Today, each of these branches of the Canadian Nurses' Association has a full-time staff of 14. The volume of work has grown to the point that more pairs of hands, more active minds are imminently required.

One of our longed-for goals was to reach "60 (thousand subscribers) in '60." We can joyfully report that that total has been reached and surpassed. In fact, our estimate is that the total joint circulation for this month's issue will be well in excess of 61,000. Quite an increase from the 6,041 subscribers of 1944!

What goal should we set next? Your guess is as good as ours. With most of the schools of nursing reporting that this fall's student enrolment is larger than ever before in their history; with increasing hundreds of wartime babies reaching the age when they are ready to launch into their chosen careers in nursing; with government-sponsored hospital care programs in active operation in most areas of our country calling for more and more staff members, we would hesitate to hazard a guess as to the probable total number of nurses who will be members of the Canadian Nurses' Association and subscribers to *The Canadian Nurse* two, five or ten years from now.

* * *

You had an opportunity in October to read the thoughtful addresses on the results of the initial examination that was made of the need for and the usefulness of a program of evaluation of schools of nursing in Canada. An expert in this field of study, Dr. HELEN NAHM, analyzed Miss Mussallem's Report and sketched a broad series of "next steps" in the course of her address to the convention body. We are pleased to be able to share this address with you for it will most certainly help you to understand the developments that must occur within the next few years if effective results are eventually to be achieved.

One of the important things to note, in your reading of this article, is Dr. Nahm's warning of the differences of opinion regarding the need for change that will almost inevitably arise. Already, murmurs of opposition have been heard from some of the groups that Dr. Nahm mentions. Before pressures begin to build up in any direction, *do* read Miss Mussallem's report yourself, then study Dr. Nahm's analysis of Recommendation I. Don't you be the nurse who doesn't know what it is all about. This *is* our business as professional women.

* * *

Many manufacturers of hospital equipment and supplies have a firmly fixed idea that nurses have little or no choice or say in what kinds or brands of material will be ordered. From our own observations and especially, from comments made to us by matrons of some of the smaller hospitals, by operating room supervisors and those in charge of central supply rooms, we have vigorously challenged the manufacturers' opinions. What do you say?

The pair of articles dealing with hospital purchasing bears out our contention, we believe, that the advice and recommendation of nurses are sought more often than not, even in the largest hospitals with ably functioning purchasing departments. Since this matter has an important bearing on advertising in our *Journal,* we would welcome your opinions.

* * *

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Random Comments

Dear Editor:

I am writing in answer to Jane Lewis' letter that appeared in the September issue of the *Journal*. The article "Bed-Pan Hands" in the June issue, referred to long exposure of skin to the disagreeable effects of soap, i.e. defatting the skin. This is, of course, undesirable in general skin care. Bedsores, however, require "special" care.

In Harmer and Henderson's *Textbook of the Principles and Practice of Nursing*, 5th ed. page 498, concerning bedsores it states "Next to an adequate diet and the relief of pressure, absolute cleanliness is the most important preventive measure." These are also the measures used in the care of a bedsore.

The step that follows cleanliness is keeping the area dry. Laundry soap was used, in four hospitals in which I have worked, for both of these steps. The drying effect of soap in the care of a bedsore is desirable, whereas it is undesirable in hand care or general skin care.

In treating an open bedsore there is always a need to prevent infection and promote healing. Although I have never used the foam treatment, I was taught not to wash off the soap but rather to pat the area dry after soaping. I regret that I do not know the origin of the method, but the principle underlying it is that the film of soap will help to prevent invasion by bacteria and at the same time help to dry the area. Other preparations that I have used are zinc oxide and castor oil, zinc oxide and alcohol, or balsam of Peru.

May I add in closing, a remark made on this subject by a doctor? "Nurses are on the verge of wasting their time if 'special back care' doesn't include a good massage to the area."

FAY BEEK, New Brunswick

Dear Editor:

Thank you so much for my copy of the October issue of *The Canadian Nurse*.

I feel very proud to have had an opportunity for my articles to be included in your magazine. I feel especially privileged to appear in the same issue with such distingushed persons as Helen Mussallem and Sister Lefebvre.

FLORENCE E. ELLIOTT, New York

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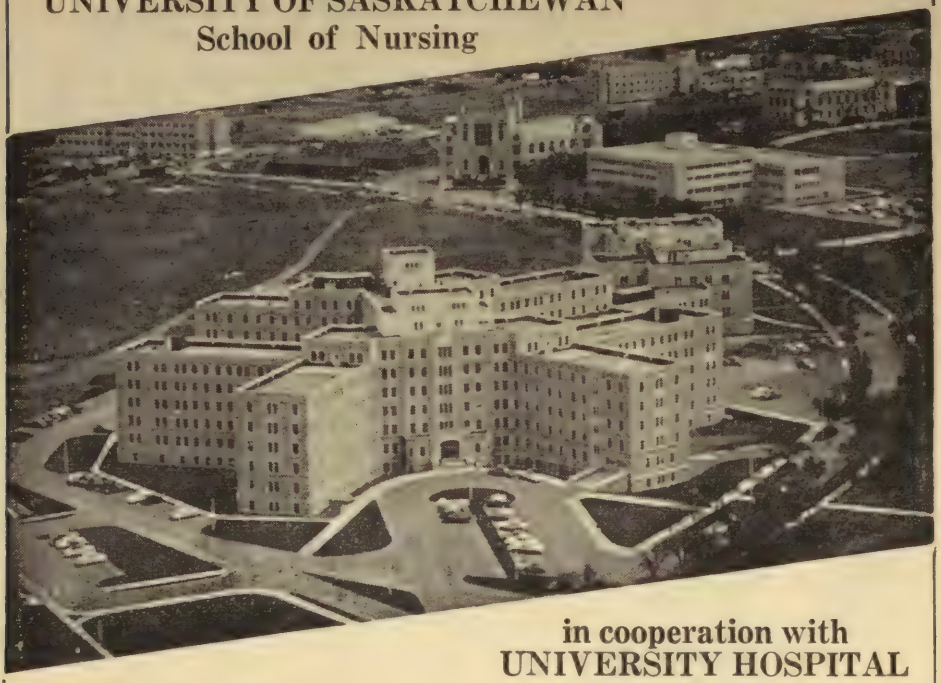
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A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 12

MONTREAL, DECEMBER 1960

NOTHING UNCERTAIN

THERE IS A LEGEND that Confucius once was asked by a disciple what he would do first if it were left to him to administer a country. Confucius replied: "It would certainly be to correct language." His listeners were astonished. "Surely," said they, "this has nothing to do with administration! Why should language be corrected?" The Master gave a typically Chinese response:

> *If language is not correct, then what is said is not what is meant; if what is said is not what is meant, then what ought to be done is left undone; if what ought to be done remains undone, morals and arts will deteriorate, justice will go astray, the people will stand about in helpless confusion. There must be nothing uncertain in what is said. This matters above everything!*

One hundred years ago, the heroic venture of the opening of the Nightingale Training School at St. Thomas's Hospital, London, established a pattern of nurse education that reached out to every continent. For nearly half of that century, Florence Nightingale participated in the wider field of public health and education through her voluminous correspondence and other writings. Acutely aware of the importance of making herself clearly understood, Miss Nightingale expressed herself forcefully. There was "nothing uncertain" in her approach to any problem.

Over the years since 1860, leaders in nursing in many lands have explored innumerable facets of nursing education and service. They too have spoken and written in a language that meant what was said. Our most recent example of this clear, forceful language is to be found in Helen Mussallem's Report of the Pilot Project on the Evaluation of Schools of Nursing in Canada. The approval by the convention body of the recommendations included in the Report has already set in motion some chain reactions that reveal a definite need for *every* nurse — not just the leaders — to be fully aware of the implications of the Report. They must strive to understand the need for the changes in the pattern of nursing education so that they may

act as interpreters. How can every nurse acquire the necessary understanding? How can they become fluent in the correct language that will enable them to interpret nursing's goals?

Sir Winston Churchill pointed out the road that every nurse might follow when he explained that though he had little enough of formal education, he had "picked up some as he went along through his reading." While we cannot aspire to emulate Sir Winston's famous skill in speaking and writing, every nurse can become more fluent if she cultivates the habit of reading good literature.

Each good book is a little universe in itself. It should be savored, lived with, thought over, relished, and all of this unhurriedly. It is better to read one good book thoroughly than to skim through fifty. Such reading will improve both our mental processes and our vocabulary. We think with words. If our storehouse of words is limited, we cannot think with flexibility and depth. Our minds become "tongue-tied."

We should read a variety of material — professional books and journals, of course, but not to the exclusion of all others. With a good dictionary available in case of need, we should find delight in new ways of expressing old ideas. All the while we will be building our own language so that it is correct — so that we say what we mean — so that there is nothing uncertain in what we say.

M.E.K.

IN THE GOOD OLD DAYS

(The Canadian Nurse — DECEMBER, 1920)

Edith Cavell Memorial — On the fifth anniversary of the death of Edith Cavell, Princess Clementine of Belgium unveiled the memorial on the Thames Embankment, given by the people of Belgium to the British nation. It represents Belgium as a woman dressed in deep mourning telling her children that Belgium will never forget their debt of gratitude to Britain.

The anniversary was observed in London as a memorial day in aid of the Edith Cavell Home of Rest for Nurses. Many wreaths were laid at the foot of the statue in Charing Cross Road.

* * *

The Cause of Warm Autumn — The warm weather in October is said to be the result of the unusual alignment of the four planets — Jupiter, Uranus, Mars and Saturn. They were all in direct line with the earth for the first time in many centuries. The combined pull of these great bodies was considered certain to affect the earth's orbit. We might expect longer summers in the Northern Hemisphere and shorter in the Southern.

It is said that a device has been perfected for rendering collisions between trains impossible. During the trial a passenger train was run at full speed past signals which were set againts it, only to be pulled up at a given point by automatic agency. It is an electric brake device on the engine, which is set in motion by a short third rail laid down at intervals along the track.

* * *

It is a well-known fact that the recent war has brought forth conditions in the nation such as in normal time would never have been dreamed of: we have been taught the great value of cooperation as shown by the accomplishment of the Allied armies, and it is now up to us to apply this lesson of cooperation to other activities of life.

Perhaps nowhere has a greater change been wrought than that experienced in the field of medicine. Human life, formerly thrown ruthlessly into a garbage pile, has finally reached its correct evaluation and has come to be regarded as a thing which must be conserved and strenghtened at all costs.

Boxing Day, December 26th, is the day chosen by the English to dispense "boxed" largesse to tradespeople and servants.

Turkeys became popular at Christmas about 1573. Prior to this, wild boar was the choice for the festive table.

Planning for the Future of Education in Nursing

HELEN NAHM, A.B., M.S., PH.D.

An authoritative opinion on the problems of evaluation and accreditation.

AFTER HAVING READ the Report of the Pilot Project I am impressed — not only with the quality of the study itself, but also with the statesmanship exhibited in the recommendations for the future of nursing education in Canada. Each recommendation complements and supplements the others. In them you are saying, "It is time to take a realistic look at where we are in nursing education today, and then to see what immediate steps can be taken to improve the existing situation." At the same time you are saying "It is time also to look to the future, and to plan with courage and foresight to meet future needs."

Recommendation I — "That a re-examination and study of the whole field of nursing education be undertaken" is the most significant. As a first or preliminary step in re-examining and studying the whole field of nursing education, we need to look at the past and evaluate the effectiveness of the steps taken over a long period of years — steps that represent our continuing struggle to control our own destiny. William K. Selden in his recent book *Accreditation, A Struggle over Standards in Higher Education,* (p. 40) states that:

> . . . in all societies the struggle for control is ever-present, and in democratic societies the privilege of publicly expressing contention and disagreement is well guarded.

This history of nursing in Canada, the United States, Great Britain, and many other countries, clearly portrays the struggle of nurses to control their own educational programs and, in so doing, to protect the welfare of the patients for whom they are responsible. Accreditation is only one method of control. The development of nursing organizations, the sponsoring of licensing laws, the initiation of extensive studies, the development of nursing periodicals, the publishing of nursing textbooks, curriculum guides and manuals of various kinds, all represent efforts of nurses to control their own destiny. In planning for the future it would be wise to study the relative effectiveness of the methods we have used in the past, and to eliminate or change those whose outcomes have been less than was initially anticipated.

Formerly associate director of the National League for Nursing and director of the Division of Nursing Education, Dr. Nahm is dean and professor of nursing at the University of California School of Nursing, San Francisco, California.

A Look at the Past

The Associated Alumnae of the United States and Canada, founded in 1896, and which eventually developed into the Canadian Nurses' Association and the American Nurses' Association, represented one of the first efforts of nurses to work together in solving their mutual problems. The sponsoring of licensure laws, which automatically made essential the setting up of minimum standards to be applied in evaluating educational programs that prepared nurses for licensure, followed the development of nursing organizations.

In the years following World War I, the period during which the inadequacies in nursing education programs were clearly highlighted, extensive studies of nursing and nursing education were inaugurated. The Goldmark Report, *Nursing and Nursing Education in the United States,* published in 1923, was the first. Studies made in the United States by the Committee on the Grading of Nursing Schools resulted in three reports, *Nurses, Patients and Pocketbooks,* published in 1928, *An Activity Analysis of Nursing,* and *Nursing Schools, Today and Tomorrow,* published in 1934. The *Weir Report,* published in 1931, represented an extensive study

of nursing and nursing education in Canada, as did the *Lancet Report*, published in 1932, of nursing and nursing education in England.

All of these studies were made by highly competent individuals. Recommendations embodied in these reports were far-reaching yet, in retrospect, we must admit that they were not implemented to the extent necessary to bring about much-needed changes in nursing and nursing education. In attempting to determine why this was so, we need to question the basic assumption underlying the initiation of all of these studies:

> that if excellent studies are made by highly competent individuals and reports of these studies are published, the recommendations embodied in the reports can and will be implemented.

For the future, we need to formulate our plans in relation to a newer assumption — one that is being widely accepted in general education —

> that the extent to which desirable changes are actually brought about is directly related to the extent to which persons concerned about those changes are involved.

This means that nurses themselves, as well as others who have a stake in the future of nursing and nursing education, must have an active part in the initial planning and implementation of studies, as well as in carrying out recommendations which evolve.

Our failures of the past are also related to the fact that, in nursing, we have had inadequate concepts of responsibility, authority and power. Certainly, nurses themselves have the responsibility for defining their own field. Society, at least in theory, accords to each profession the authority essential to carry out this task and to develop standards necessary to protect the quality of education through which professionals are prepared. Too often, however, we nurses have tended to say "We alone have the answers, and we are right." We have then attempted to use force to bring about change. In the process we have overlooked the fact that other groups such as hospital administrators, the medical profession, educators and dissident groups in our own profession also think they have the answers — that they are right about what nursing is and how nursing students should be educated. These groups, too, have power and they may attempt to use force to get their own way. The only possible outcomes are either that one group will eventually win out over the others, or that several groups will join forces to defeat a group with which they disagree. The fact that nurses have not won many of the battles of the past is dramatically highlighted by the continuing weaknesses in nursing education and nursing service programs. In *Fundamentals of Administration for Schools of Nursing,* (pp. 12-13) it is pointed out that

> When different or conflicting interests of two or more persons meet, the method of adjustment may be any one of four types:
>
> 1. Voluntary submission of one side, in which the adjustment is in one direction only;
>
> 2. struggle and victory of one side over the other, in which the defeated are compelled to do the adjusting;
>
> 3. compromise, in which each side makes concessions until they meet somewhere along a scale of values;
>
> 4. integration, in which neither side makes concessions to the other, but the adjustment is achieved by a new synthesis which satisfies both. The latter method is described as both interactive and creative.

Planning for the Future

We must begin with the basic assumption that "nursing shares with other health professions the responsibility for assessing present and future health needs of people in this and other countries of the world, and for planning to meet these needs." If we accept this assumption we must attempt to determine what the health needs of people will be in the years to come and what it will be possible to provide. We then need to ask ourselves such questions as the following:

> 1. Who will our patients be? What kind of care will be needed by the chronically ill and aging, the mentally ill, the tuberculous, mothers and children, and many other groups? Are there other groups in our society who should be looked upon as sick — alcoholics, delinquents, criminals, and do we share, with other professions, the responsibility for their care?

2. Where will our patients be cared for? Will we continue to provide 24-hour care for the majority, or will there be an increased development of home care, outpatient, and day-night services? Will the character of general hospitals change as maximum and minimum care units and convalescent services are provided?

3. What will be the probable changes in medical practice? Will the highly prepared medical specialist pass on to the nurse many of the comforting and supporting functions formerly performed by the family physician? Will he delegate additional technical functions? If so, is the nurse the best prepared person to carry these out?

4. What will be the probable effects of these changes on nursing practice and the organization of nursing services?

5. What will be the probable effects of these changes on nursing education?

a) Is there a need for nurses to be prepared at more than one level? If so, what kinds of educational programs in nursing are needed? What changes should take place in existing programs?

What is the future role of collegiate nursing programs? Of diploma programs? Of vocational nursing programs? How should students be recruited and selected for the various types of educational programs in nursing?

b) How many and what kinds of nurses are needed for leadership positions and how should they be prepared? Should we attempt to prepare highly expert clinical practitioners in nursing? If we prepare them, will they be employed by nursing service agencies, and will they be given sufficient remuneration to compensate them for expending the time and effort necessary to become expert practitioners?

c) How much can be encompassed in a basic program in nursing education? How skilled do we expect a beginning practitioner to be?

d) What kinds of in-service and continuing education programs are needed to help employed nurses improve their own practice? Who should be responsible for the development and financing of such programs?

e) How can we prepare nurses for research in the nursing field?

6. How many and what kinds of nurses do we have at present? How well-prepared are they for the positions they hold? How well are they distributed? What are their ages, their marital status, their plans for the future?

The inevitable result of seeking answers to questions such as these, will be a clarification of goals for the nursing profession and the formulation of principles to be applied in planning action programs essential to the achievement of these goals. Too often in the past, opinions of strong individuals or groups have been vehemently stated. Too seldom have the basic principles underlying those opinions been clearly elucidated. Principles can be defended; they can be used to educate those who initially do not see things as we do. Opinions, on the other hand, are often difficult to defend, and are much more likely to divide than to unify groups. We must also assess the social, political and economic forces that have already brought about widespread changes in nursing and nursing education and that will continue to bring about changes in the years to come. We must take into account the human emotions that are aroused when widespread changes take place and anticipate the possible consequences of following one plan of action or another.

The Changing Role of the Nurse

Prior to World War II, when the word "nurse" was used, the picture that came to mind was of a graduate of a three-year hospital school program who gave direct care to sick patients. When the word "nurse" is used today the picture may reveal an aide trained on the job, a practical nurse, a graduate of a traditional diploma program or a graduate of a college or university program.

The professional nurse of the past took great pride in being a graduate of a distinguished hospital school of nursing. Present criticisms of hospital schools, coupled with the emphasis on the importance of collegiate education for the nurse who functions at a truly professional level, have upset old patterns of loyalties for many practising nurses. Anselm Strauss, in *Mirrors and Masks,* (p. 108) states that:

When organizations and institutions are expanding, forming, disintegrating, or in any way changing radically, the personal lives of their members are rendered more tortuous and uncertain and, at times, more dangerous and exciting; such changes dog not only the old-timer, but also the novice who blindly follows old career patterns.

He talks about the importance of identification to the individual. When we ask a person to turn his back on the past and dis-identify himself with old practices and to question certain important "me's," for a time, he is midstream between danger and discovery. To survive, he must regain his world and must develop new concepts about what is worth striving for and fighting for. "To be deeply involved in a course of action is *to care, to be concerned, to be identified* with it."

The professional nurse of the past took great pride in giving high quality bedside nursing care. In the majority of hospitals today much of the direct personal care is given by practical nurses and aides. The professional nurse performs technical, administrative and supervisory functions but her role is not clearly defined. She faces pressures from administrative personnel to assume administrative and supervisory functions for which she usually is not prepared. At the same time, she is pressured by physicians and patients to assume traditional care roles that the work situation often makes impossible.

Alan Treloar and Don Chill, in a recent article in *Hospitals* (32:42), define nursing as "a multifaceted, paraphysician service and . . . the fact that it is multifaceted, rather than unifaceted, is the major reason for the dilemmas the nursing profession faces." We ask nurses today, particularly those in responsible positions, to plan, to administer, to teach, to supervise, to study, to read, to think, to communicate, to understand, to evaluate and to do research. This is a large order, even for the young, the highly motivated and the well prepared.

The Effect of Change

Not only must the reactions and feelings of nurses themselves be anticipated in planning action programs for the future, but also reactions and feelings of others who will be affected, either directly or indirectly, by changes which take place. When changes are made in educational programs in nursing, administrators and boards of trustees of hospitals that conduct schools of nursing, doctors, and patients and their families will be directly affected. Administrators in colleges and universities that conduct collegiate nursing programs are also likely to be concerned. Hospitals and other agencies that employ nurses, but do not themselves conduct educational programs, are affected indirectly. Any movement that has a direct effect on the public welfare is likely to create concern on the part of many groups within a society, even though these groups are not directly affected.

Nurse leaders of the past have certainly had justifiable reasons for concern about the quality of educational programs in nursing. In their zeal to bring about change they have often taken insufficient time to educate the groups likely to be affected by changes. As a result, the methods used came to be regarded as revolutionary rather than evolutionary.

As an example: An extensive study was made in 1949 in the United States by the Sub-Committee on School Data Analysis of the National Committee on the Improvement of Nursing Services. Following the study, the *Interim Classification of Schools of Nursing* was published, with the upper 25 per cent of schools classified as Group I schools and the middle 50 per cent as Group II schools. The lowest 25 per cent, the Group III schools, were not listed. When the Interim Classification was published the schools of nursing were promised that a follow-up study would be made within two years. The National Nursing Accrediting Service was asked to accept responsibility for the second study. Instead of a second listing it was agreed that a program of temporary accreditation would be developed.

Hospital and nursing service administrators, boards of trustees of hospitals, medical associations, both state and national, administrators of colleges and universities, and many other groups reacted quite antagonistically in many instances, to both the Interim Classification of Schools of Nursing and the Program of Temporary Accreditation.

Yet, when efforts were made by the staff of the National League for Nursing and nurse leaders associated with various types of educational programs in nursing to meet with dissident groups and to include them in future planning, attitudes of the groups usually underwent marked changes. Many persons who initially came to criticize, remained to help implement what soon came to be known as a nation-wide program to improve schools of nursing. Perhaps, if more time had been taken initially to gain the support and understanding of all concerned groups, the program of school improvement might have moved along at a more rapid pace, with far less trauma to the schools of nursing themselves and to all persons affected by changes in the schools.

To look into the future of nursing and to plan realistically to meet future nursing needs is a formidable task. Its success will be directly related, not only to the clarity of the goals, but also to the methods used to achieve them.

Planning for Accreditation and School and Service Improvements

Though I have focused primarily on implementation of Recommendation I, there are factors to be considered in implementing Recommendations 2, 3 and 4. The difficulty of initiating a school improvement program and an accreditation program, without at the same time initiating a program to evaluate the quality of nursing service in those areas where students receive their clinical experience, is recognized in the recommendations. This is most important. Although educational programs exist, essentially, to prepare students for future service, there is a direct relationship between the quality of nursing care which students observe and the effectiveness of their educational program.

Many changes have occurred in both the philosophy of accreditation in higher education and the procedures that are developed. The procedures now being recommended by some accrediting agencies in the U.S. focus heavily on the need for improvements in educational programs. An educational program should be judged in terms of the purposes it serves. The function of an accrediting agency is to stimulate self-study and self-evaluation. This is in direct contrast to the old procedures which focused on highly specific and largely quantitative standards.

Many problems associated with accreditation have not yet been solved. These may be summarized as follows:

1. Institutions continue to be confronted with many criteria and voluminous questionnaires. Yet, few criteria have been verified to ascertain their reliability in distinguishing good from poor institutions. No method has been found of determining the merit of an institution in relation to either what happens to students during their period of enrolment or to their effectiveness following graduation.

2. Survey visitors and reviewing groups still carry heavy responsibility — not only for sound decisions, but also for constructive and unbiased suggestions.

3. The relationships between professional accrediting agencies and state licensing boards (in the U.S.) have not yet been clarified.

4. In collegiate schools of nursing the extent to which the college or university accepts responsibility for professional education directly affects the quality of such education.

5. There is potential conflict between the focus on self-study and self-evaluation, and evaluation by others. Accreditation, ultimately, represents evaluation by persons from the outside. The less able a school is to evaluate its own program, the more it tends to look upon evaluation by others as a threat.

6. The extent to which survey visitors can be objective is related to their own training and experience.

7. Strong schools may benefit little from the accreditation process; yet, unless they are willing to participate in an accreditation program and to help weaker schools, the entire process of accreditation will be ineffective.

8. It is difficult to decide how frequently resurveys should be made, and how comprehensive they should be, particularly where strong schools are concerned.

9. The costs of accreditation continue to be high. Unless some method of spreading the costs can be found, they will continue to be inordinately high for the individual school.

A number of critical problems as-

sociated with accreditation are pointed out by William K. Selden in *Accreditation, A Struggle over Standards in Higher Education.* Among these are the following:

1. The opposition encountered from persons whose previous education is threatened by implication,

2. the opposition encountered from individuals who operate schools with low standards; if operated for profit, criticism of them creates an immediate economic threat to their owners,

3. the relationship between the emphasis on the importance of professional accreditation and the desires of individuals to attain a high vocational status.

In discussing the latter item Selden makes the following statement:

> Not only do they (professional associations) aim to create an organization which will foster research, advance learning in the profession and improve service to the public, but they develop an impelling motive to raise individual status by restricting admission to the profession — sometimes with more emphasis on the interests of practitioners than on the public welfare.

Though pointing out the many inherent difficulties in the accreditation process, Selden also emphasizes its values. In a recent article entitled *Why Accreditation* he states that even though no subject seems to elicit such a variety of responses from educators, many of which indicate a lack of previous and accurate information, the overall values of accreditation have been great. These values are summarized in the following statements:

> The influence of accreditation and the potential threat of disaccreditation have served as a countervailing force in situations where influences, both external and internal, could have conceivably subverted a college or university from its rightful purpose.
>
> I insist that accrediting is a manifestation in education of our form of civil government and political control, and as such, it is an integral and irrevocable part of the structure of higher education in this country. But I equally insist that just as we must exercise greater inspiration in realigning some of the various government procedures and responsibilities to care for the immense growth in population and the rapid technological and social changes, in the same way we must submerge local pride and selfish interests and must use imagination in revitalizing accreditation so that it is more of a constructive than a standardizing force in education.

Educators who continue to be concerned about improving accrediting procedures emphasize the need to recognize differences among schools — differences in purposes and objectives and in admission and retention policies. Norman Burns, Secretary, North Central Association of Schools and Colleges, recommends that:

> institutions publish more accurate descriptions of what they do, what admission requirements they set, what kind of students they wish to educate, what becomes of their students after graduation, and what significant differences there are between the highly selective and the less selective.

He feels that fuller information about institutions would have great public value and would help prevent invidious comparisons.

In implementing the Pilot Project recommendations that there be simultaneous development of accreditation and school improvement programs, Canadians will profit from the experiences of both general and professional accrediting agencies in higher education and, in so doing, build a constructive and positive, rather than a standardizing program. Through a school improvement program, early contact can be made with schools of nursing to provide guidance and to become familiar with their problems. An association over a period of time will help many to make the changes that are essential in meeting criteria for accreditation. As your program develops perhaps you can publish the kind of descriptive list recommended by Dr. Burns, rather than the kind of list that merely states that an institution is accredited.

In closing, a statement made recently by Robert Gordon Sproul, President Emeritus of the University of California, seems appropriate:

> There are times when institutions, like individuals, must pull themselves up by their own bootstraps, and the present era of widespread reappraisal of educational values would seem to be one of these times.

The Patient Returns to the Community

Isobel MacLeod, M.A.

Total patient care requires the cooperation of many disciplines. Good human relationships are a prerequisite to such cooperation.

For many years we, in nursing, have recognized that we must think of our patient in his total environment; that there is always an emotional and social aspect to his illness and its cure. This has made it necessary for us to plan from the beginning of his hospitalization for continuation of the nursing care that he will need after he has returned home. It makes it necessary, too, to include the patient himself, his family and other professional workers when we are planning total care. We are presently concerned with the problem of how we may function most effectively in promoting this coordination of effort in order to bring about the maximum rehabilitation of our patients.

Organized hospital home care plans are a recently developed channel to promote coordinated effort between workers, both inside and outside the hospital, with those individuals who are most important of all in the patient's final rehabilitation — the members of his family. Because we know that the patient benefits from human relationships, we recognize that often his home is the place where he can receive the greatest measure of supportive care. This is especially true in the care of children, of the elderly, and of long-term patients. Caring for the sick at home presents many problems. The family will need help from a number of agencies, including the hospital. Rather slowly, hospitals are beginning to provide the necessary comprehensive services. It is to their credit that nurses, of their own initiative, made a beginning in this direction by establishing liaison programs between certain hospitals and Victorian Order nurses in order to provide continuity in nursing care.

Mrs. MacLeod who is director of nursing, Montreal General Hospital, presented this paper at the CNA biennial meeting in June.

The Role of the Family

Sometimes, for a variety of reasons, a patient cannot be cared for adequately at home throughout the entire course of his illness. In such instances, we should endeavor to transfer the healing aspects of the home to the hospital as a definite part of therapy. This has been done successfully in the more advanced pediatric institutions. The parents are encouraged to be present and to take an active part in the care of the child. The problem in adult general wards, however, is more difficult to solve. Some hospitals have gone the full way and have permitted unrestricted visiting. Others have been more conservative. The fatiguing effect of large numbers of relatives and friends constantly at the patient's bedside has been observed. Visitors in quantity demand a kind of social interaction that the sick are frequently not capable of providing without damaging strain. Is there not a responsibility on the part of hospital authorities



Isobel MacLeod

to make better use of family members when they do visit? Perhaps visitors should be limited to a stated number and should be people whom the patient really wants. After he has told his doctor or nurse in confidence whom he wishes to see, should not these persons be permitted very generous visiting privileges? Surely it is then the responsibility of those caring for the patient to take from him the burden of less welcome visitors. This responsibility would require the utmost skill, kindness and good will. The chosen visitors should be encouraged because they can give comfort to the patient and they can become helpful members of the therapeutic team.

Team Conferences

Another channel through which we can promote coordinated follow-through from hospital to home is the regular planned conferences of all the workers concerned in the care of a patient from the very beginning of his hospitalization. These should be instituted and continued until we are sure that the patient has reached his maximum rehabilitation. Such conferences are coming into popular practice, especially for the long-term patient who has special problems. They bring together hospital and community workers with special skills. They include physiotherapists, dietitians, occupational therapists, social workers, occupational nurses and others. It is essential to ensure that meetings are called only when they can be useful. Most of us have attended gatherings where mutually helpful relationships failed to be established and we have regretted the time wasted. But this should not deter us from striving to overcome the professional isolation in which the various groups of the health services all too frequently work. We should discipline ourselves to hold at least one such comprehensive planning conference for virtually every patient. The minimum composition of this group should be the doctor, the nurse, the patient, and at least one member of the family. Of course, modifications may be necessary. At times, the patient may not be able to participate even in a brief consultation at his bedside, but usually he will be able to participate eventually. The "family" in some instances may not be an actual relative. However, if there is anyone in the patient's life who will be meaningful and helpful to him after discharge, that person should be included in the planning.

It may not always be possible to have every member of this team present at every conference. It may not even be possible, regrettably, to have everyone together at any one time but it does seem that communication among these four basic people is essential, if a workable plan for rehabilitation is to be developed. It also seems that the person in the best position to ensure successful communication between all concerned is the nurse. Many times it can challenge the best that we can give in intellect, skill in human relations, patience, compassion, and understanding. I believe that if this coming together were considered by doctors and nurses as a required part of every patient's cure, and as a procedure that it would be unthinkable to omit, we would see dramatic changes in patient recovery, in family unity and in personal satisfactions on the part of those in attendance.

I am aware that many people say, when this is mentioned, "But we *do* have this communication." I know that we do *sometimes*, but do we not betray our lack of understanding of the place of such communication as an essential part of the healing process when we do not provide it systematically for all patients?

It has been mentioned that all too often our conferences fail to establish the degree and kind of communication that is necessary for the effective working of a health team. The whole success of any means that we may devise to coordinate our efforts to return the patient to his normal environment depends upon our ability as professional people to work constructively as partners. It is essential to have the desire and the sensitivity to feel what another is feeling; to be able to give ideas and to question ideas in an acceptable way; to contribute, so that others are strengthened in understanding and in self-esteem; in short, to become a part of a working group from which the members emerge with more knowledge, more confidence, more inspiration, more respect for themselves and others. This is health as applied to working

relationships. It is what we want to achieve in order to provide the best for our patients. In order to do so, we need an abundance of this kind of health ourselves. Perhaps this is something that we, who practise the healing professions, should pursue more consciously. Our concern as nurses is to be sure that the experiences we create for one another, as we practise and as we educate student nurses, promotes this broad aspect of health. We have to place more emphasis on the development of working relationships which are, in themselves, abundantly fulfilling.

Does the experience of the general staff nurse in the hospital do all that can be expected to develop enjoyment from giving direct patient care? Does it stimulate a desire for more knowledge and skill? Does it promote enthusiasm and self-esteem? Does she receive from those around her the feeling of status that the expert practice of bedside nursing should give?

Many of us feel that more should be done to give the general staff nurse the satisfaction she deserves and must have before she can give fully to her patients and co-workers. Nurses are treated, for the most part, with justice and courtesy. Personnel policies are usually fair. This is not enough! What else can be included? Beginning with the arrival of the new nurse, we can take steps to ensure that her reception, her orientation program and later her participation in an in-service educational program and staff association activities will be such as to give her a feeling of status, respect and partnership in a strong, cohesive, working team. I am sure many of you could add other and better ways.

There is one factor above all others that is of paramount importance. If it is good, it can offset weaknesses elsewhere. If it is poor, other influences will not compensate. It is the day-to-day working relationships on the ward. The leadership skill of the head nurse in promoting work satisfaction by requiring a high standard of patient care along with the promotion of a high standard of staff morale is what we are most dependent upon here.

To sum up it might be stated again that the great barrier to effective functioning is working in isolation. This might seem like an over-simplification, but the contrary is true. Even among a staff of 18 or 20 on a single unit, the nurses can be isolated psychologically from one another. They may meet daily for reports and team conferences. Sometimes a head nurse can bring to these meetings ways of promoting rich relationships. On the other hand, she may find that other conferences are necessary to bring into the open both dissatisfactions and ideas for improvement. So often I have seen poor relationships perpetuated because people are not brought together by someone with the skill to promote constructive communication. We have to keep in mind, too, that none of us can do our best work when we are too isolated. We need adequate communication with others who are struggling with the same problems. Regular meetings of small groups of head nurses are essential, if they are to obtain the release of tension and the stimulating companionship that will enable them to give generously to their staff. How to make these conferences meaningful would take a book. Indeed, books have been written on the subject. I do believe though that if even the first step is taken and isolation is overcome by bringing people together constantly and regularly, with goodwill, in time a creative process will develop.

What of student education? Surely, the same needs are seen here. We have added much to the curriculum in the way of psychology, human relationships, sociology, human development. We carry this over quite well in clinical teaching through practical applications in meeting individual patient needs. The need is not for more teaching, but for more experience in working together effectively. While we teach much about human relationships in our schools of nursing, many of you will agree that what is taught in theory is not necessarily translated into practice. Sometimes, those who can quote the theory best have a great deal of difficulty when it comes to practice. Thinking back to the necessity to produce nurses who can work with other professional workers to promote the patient's return to the community, it seems that the provision of opportunities for students to experience satisfying relationships should be an essen-

tial part of the curriculum from the day they enter the school until the day they graduate. To promote the qualities and skills needed by nurses for the future, we will be required to use all of our ingenuity in finding varieties of ways for them to experience democratic relationships among themselves and with others in small groups in solving mutual problems. These problems may be ones of group living in residence, which are dealt with by means of the student association and student government. They may be problems of patient care on the ward. Students require the guidance of teachers and administrators who can help them develop the skills of identifying with another's viewpoint; feeling and accepting another's feelings; coping with anger and mending relationships after conflict; and especially in receiving pleasure and satisfaction from working with others.

Soliloquy of a Purchasing Agent

ARNOLD SHARPE

Purchasing hospital stores entails much more than an order pad and pencil.

WHO AM I? What am I doing wedged for hours within four walls? Vendors! Catalogues! Directories! Price trends! Commercial registers! These hum through my head in a dizzy tune. I glance at the door and read my title through the glazed pane: **"tnegA gnisahcruP"** — an apt symbol of just how I feel after dismissing the 11th salesman since eleven o'clock. But the 11 salesmen could not have read what I am reading or they would not have had the heart to knock at my door. Of course not! They read it from the outside, and to them it spells hope. I stand for their bread and butter. Purchasing Agent! An agent — one who acts for another. The sudden awakening to consciousness of whom I am acting for pulls me up from any weary slump and directs my glance to my memos for tomorrow.

9:00 A.M. See the supervisor of Central Supply about chest suction. Oh, yes! She wants some new-fangled apparatus that she probably saw on exhibition at the convention. I wonder why people can't be satisfied with something that already does a good job, without getting all excited about everything new that comes along? Moreover, how can it possibly benefit the supervisor to get new equipment? She hasn't enough space for her equipment now. There must be something behind this. Better patient care? Perhaps. We'll talk it over.

9:30 A.M. See storekeeper re: anesthetic supplies. Check on new helper. I'm sure he's what we want. It might encourage him to have me drop in and ask how he's getting along. I must stop off at the print-shop to see what's holding up the work on the storeroom catalogues.

10:00 A.M. Agent from suture company. I wonder how he'll handle the complaints about the needles! I was *sure* I had snatched the best offer. There are so many things one has to keep in mind. It's hard when you're bombarded with clever sales talk.

11:00 A.M. Salesman for acid proof, flame resistant, waterproof, washable mattresses. I mustn't keep him waiting as I did the last time he came! I have to keep reminding myself that time is valuable to those fellows too. Besides, we need them. It would be pretty hard to be selective enough if we had to race around to all those firms to test quality.

1:00 P.M. Staff meeting — hospital auditorium. Here's hoping I can clear up once and for all this annoying business of half completed requisitions. Administration asked me to highlight the new procedure manual. That should work in without getting me

Mr. Sharpe is purchasing agent at St. Mary's Hospital, Montreal.

labelled "Crank No. 1!"

2:15 P.M. Salesman from — no, that's cancelled! One precious hour to think and plan. We simply *have* to cut down costs or I'm not worth my salary. It isn't right for room rates to be raised to offset the mistakes of management. This is the place we can save the dollars without antagonizing the personnel and upsetting morale. It's a good chance to boost morale with our "economy of effort program."

3:30 P.M. Visit to laundry equipment firm to wind up the day. They have good extractors, I'm told. Three hospitals in the city are using them with satisfactory results.

Speaking of laundry, I must get the hospital supervisors together and let them in on my little research project. I'll prove to them how we can save money by standardizing our detergents and still have everything just as clean as ever. Why eight women have to have eight different ideas about what is best in detergents is beyond me! I suppose I *could* blame T.V. but that wouldn't simplify the problem.

Well, if I don't leave now I'll be late for the big dinner and demonstration of the respirator. I wouldn't miss that for anything. Come to think of it, a patient's life might depend on whether or not we purchase that equipment. If we rent it, they have to wait for it to arrive. While they wait, they have to pay. You just can't get away from it. It is the patient who benefits when we buy wisely. To buy or not to buy, that is the question.

PURCHASING - STORES

SISTER MARY ASSUMPTA, B.Sc.

The basic purpose of any hospital is to provide the best possible service at the lowest possible cost.

IN ORDER TO carry out its basic purpose, as many as 22 separate departments may be called into play in a hospital. The Purchasing Department is one of the most important. It is a *staff* department, in an organizational sense, in that its services are available to all other departments of the hospital, but it does not exercise any direct line control or authority over other departments. This department must handle its work in such a manner as:

1. To effect purchase of high quality hospital supplies at the most favorable cost;
2. to ensure an adequate supply of the required kinds of materials and supplies in order to maintain the most efficient level of operation and meet the demand of all departments.

There are various means of accomplishing this through proper and adequate purchasing policies. One such policy is centralization of authority in one purchasing office, as is our practice at this hospital, with the exception of pharmaceuticals.

By centralized purchasing, we understand that the procurement of all purchased materials and supplies is concentrated in or channeled through a single department, under the direction of one responsible person. The more centralized the authority of purchasing, the greater the interdepartmental responsibility. An important reason for a centralized system of purchasing is that it acts as a time-saver for our department supervisors. We can direct our full attention to the operation of our departments since we are relieved of the obligation of interviewing sales representatives. This is the responsibility of our purchasing agent, in whom we have placed our confidence. On occasion, at the discretion of the purchasing agent, a department head may be invited to the purchasing department to consult with an agent in order to obtain information or to supply it.

Sister Assumpta is supervisor of the obstetrical department, St. Mary's Hospital, Montreal.

———————Hospital

Serial No.

Place X Opposite Designations Desired	Daily Weekly Purchase	**Requisition on**	Store Pharmacy Maint'nce	Printshop Dietary Laundry

For use in Dept. Charge to Account No. Date 19

Instructions: Requisitions should be written neatly and clearly. All items should be described exactly by Code, Catalogue No. or size. Weekly requisitions must be approved by Department Head before delivery to Purchasing Office. Put only stock items from the same grouping on this requisition when drawn on the storeroom.

Please Repair / Deliver the following In: To: Do not write beyond this line

On Hand	No. Wanted	Unit	Catalogue No.	Name of article or repair requested and full description	Amt. Issued	Unit Price	Extended price	Store-keeper Remarks

To be purchased from

Date Order No.

Purchase approved by

..... *Administrator*

Requested by

Approved by

Approved by

Filled by

Received by

Requisitioning

Our requisition form is used effectively for every type of repair, supply and purchase needed by any department. When it is a matter of repairs, the form is filled out, signed by the supervisor of the unit and sent to the nursing service and purchasing offices. When approved by the administrator, the requisition is forwarded to the chief engineer of our maintenance department.

If the repair is effected by hospital staff, the person who made out the requisition originally signs it after the work has been completed satisfactorily.

If the repair is to be made by non-hospital staff, the purchasing agent forwards the receiving copies of the purchase order to the department requesting service. Both of these must be signed by the original signee and returned to the purchasing office when the work has been satisfactorily completed.

Spaces are provided on the form for the date, the department, description of supplies, quantity ordered and quantity delivered so that, in the event of stock shortages, a back order may be written for delivery of the balance as stocks become available. Proper signature spaces are provided for the individual initiating the requisition and

the persons approving the request. Space is also provided for the signature of the storekeeper and finally for the individual who actually receives the goods.

Requisitioning does not always lead directly to a purchase. It may result merely in the sending of a requisition to the Stores Department, where the need can frequently be met. A loose-leaf storeroom catalogue indicates the supplies that are kept in stock. This catalogue, adequately planned and properly maintained, tends to promote both uniformity of description and uniformity of purchase.

All items in the storeroom are classified under eight control groupings:

Group 1. Glassware, china, cutlery, metal smallwares excluding soap and paper towel dispensers and containers.

Group 2. Housekeeping: Soap, toilet tissue, cleaners, wax, floor brushes, tray covers, paper towels and cups, napkins, mops.

Group 3. Laboratory: All supplies associated with laboratory work — slides, test and culture tubes, pipettes, I.V. apparatus including I.V. sets.

Group 4. Medical and surgical: Syringes, catheters, dressings, plasters, razor blades, creams, etc.

Group 5. Office supplies and stationery, all forms.

Group 6. Textiles: All finished and unfinished goods, uniforms, aprons, sheets, rubber and cloth sheeting, etc.

Group 7. X-ray supplies: Films, developer, fixer etc.

Group 8. Dietary: Canned, dried and non-perishable food stuffs.

When ordering stock items, we list only items from one group on any one page of the requisition. This is absolutely essential for inventory control and pricing.

Monday is the day assigned for completing requisitions to be sent to the storeroom. A "want" slip is clipped to the front of the storeroom catalogue on which supplies, that have reached reorder point, are recorded from day to day. Then it is just a matter of spot checking other requirements from the storeroom to make provision for the next week's demands.

The responsibility for ordering is given to the supervisor of the unit. The task of making out the requisition is, actually, performed by our trained ward secretary. The supervisor checks and signs the requisitions before they are sent to the nursing service department for approval. All requisitions for the week's delivery must be in the purchasing office by Tuesday noon of each week. There they are numbered, then examined, relayed to the administrator for approval and forwarded by Tuesday night for disbursement. Delivery of goods is made on Thursday and Friday. Orders are honored only when submitted on the proper requisition and when signed by a specifically authorized person. All requisitions are subject to administrative approval, except in the case of emergency.

The original requisition is returned with the supplies when the storeroom clerk delivers them to the unit. The person who originally requested the articles must personally receive and check the items and sign for those received in the space provided. The requisition is retained by the stores clerk so that the goods may be charged to the specific department. If an item is not in stock, the requisition is appropriately marked "Back Order" in the "Storekeeper's Remarks" column. Delivery is made as soon as stocks are available.

Defective or incorrect merchandise is returned to the storeroom immediately on discovery, together with a requisition form stating the quantity, description, etc. and the reason why the items are being returned.

Purchase Orders

Requisitions are routed through the office of the purchasing agent to ensure conformity with general purchasing procedures. The serial and purchase order numbers are provided by the purchasing department and do not concern the requisitioner. We find it a good practice to make a copy of the requisition. The copy is retained on file in the department. The original is forwarded to the purchasing office.

Department heads consult with the purchasing agent periodically and convey their intimate knowledge of products used in their departments. This acts as a guide to further buying. The purchasing agent acts or serves as a middle man between the using department and the various sources of supply.

Any new item is always investigated and the opinions of the personnel respected and considered when purchasing is to be done. Suppliers qualified to furnish a particular item are requested to submit prices and other data consistent with the hospital's needs. Upon receipt of quotations, the purchasing agent takes all things into consideration and buying is done on a bid basis.

In many cases involving requisitions for new equipment or replacement of old equipment, the request is referred to the administrator of the hospital for approval as is the case with stores requisitions. Such items may have a direct effect on the operating budget.

The budget is no more, nor less, than another administration tool. It simply points the way for those who must make decisions. The primary purpose of hospital budgeting is to forecast future financial planning. A purchasing budget is a very necessary adjunct to hospital administration. It should be flexible enough to allow for emergencies within a reasonable scope. Changes in circumstances may allow re-evaluation of needs that will effect savings.

In conclusion, since the purchasing agent administers and directs a program to purchase supplies, equipment and services, he contributes daily to the care of the patients. This makes him, as surely as the doctor and the nurse, a member of the hospital team.

Our Nurses Plan Their Time

RITA M. BALL

Careful planning of nurses' time results in meeting the nursing care needs of patients and the leisure-time needs of nurses.

NURSES WHO HAVE WORKED a 12-hour day with two or three hours off will remember that this off-duty time was frequently of little benefit to them. How often it was used for sleeping because it was too short to be spent in other activities and occurred at an inopportune time of the day or night!

With the advent of the 40-hour week and three shifts, the question of planning hours off no longer exists in most institutions — but what of days off? These can be planned in such a way that the staff knows well in advance, the periods that they will be working and the days that they will be free. They can then plan their leisure time with the assurance that they will not have to change their plans to meet nursing service needs.

Establishing a Pattern

The first step in planning is the setting up of a staffing pattern. A pattern such as the following can be adapted to most staff set-ups. The sample rotation plan shows the pattern for each nurse. This pattern is repeated over and over. Each nurse on the unit works the same pattern. In order to provide a coverage of five nurses in each 24-hour period, each nurse is at a different point in the pattern on any one day.

Features of the Plan

Charge nurses are not included as they work 7-3 Monday to Friday, with Saturday and Sunday off.

The plan permits posting of a rotation pattern for three or four months or longer, since nothing is allowed to interfere. When a nurse leaves the staff, her shifts are filled in as needed by relief staff until a new nurse arrives. She is then given the vacancy in the pattern without altering the rotation.

The 10 statutory holidays are planned individually and may be arranged before or after days off, excepting

Miss Ball is director of nurses at the Trail-Tadanac Hospital, Trail, British Columbia.

those adjacent to the 11-7 shift. Nurses who can only work on a part-time basis, relieve on holidays so that the shift pattern is not disturbed.

Night duty periods start on Friday so that the four days off following this period always occur over a weekend. It also works out that the second period of four days off includes Saturday and Sunday. (following the second shift of 7-3)

Advantages of the Plan

1. It is not necessary to follow this particular pattern of seven periods of duty between days off. The nurses may prefer to work a pattern of 10 periods on duty and 4 days off, for all shifts.

2. In any pattern each nurse can plan her time, all are treated alike, i.e. all have an equal number of week-ends.

3. The person directing the pattern can see in advance exactly where, when and for how long relief is needed.

4. The nurses who do part-time work can arrange to come in because it is possible to tell them in advance whether their services will be needed for one period of duty or seven.

5. The charge nurse is not required to make out a time sheet. The rotation patterns are made up in the nursing office and are alike for each unit.

6. A regular pattern helps to encourage good staff relationships. Each nurse can see the rotation of others on the staff and knows that all are being given equal advantages.

When nursing staff is kept at a minimum level it is necessary to have a sizeable list of nurses on call for relief. In this way, staff nurses are kept in their own departments. This is to their satisfaction. It also enables the person who is responsible for staffing to know exactly when and on what period of duty extra help may be necessary.

The plan has been so satisfactory for nursing staff in this hospital that it has been adapted for use in planning time for the nursing aides, orderlies, janitors and janitresses. The patterns are not identical but the principles are the same.

The staff is happier and more willing when their time off is planned with their interests considered as well as the welfare of the patients.

SAMPLE ROTATION PATTERN

Date:—

Day of Week:—	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S
Charge Nurse:—	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7	7	7	7	—	—	7	7
Gen. Duty #1	3	3	—	—	11	11	11	11	11	11	—	—	—	—	3	3	3	3	3	—	—	7	7	7	7	7	—	—	—
2	—	—	3	3	3	3	3	—	—	11	11	11	11	11	—	—	—	—	3	3	3	3	3	—	—	7	7	7	7
3	7	7	7	7	—	—	—	—	3	3	3	3	3	—	—	11	11	11	11	11	11	—	—	—	—	3	3	3	3
4	7	7	7	—	—	7	7	7	7	7	7	7	—	—	—	3	3	3	3	3	3	—	—	—	—	7	7	7	7
5	3	—	—	7	7	7	7	7	7	—	—	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	—	—
6	—	3	3	3	3	3	—	—	7	7	7	7	7	7	—	—	—	—	3	3	3	3	3	3	—	—	11	11	11
7	11	11	11	11	—	—	—	—	3	3	3	3	3	3	—	—	7	7	7	7	7	7	—	—	—	—	3	3	3

25 BED UNIT

7—3 shift on Saturday and Sunday short staffed.
Relief help called in where and when needed.
Statutory Holidays taken on 7—3 or 3—11 shifts only.



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Season's Greetings

National Office staff joins in extending greetings to nurses everywhere for a holy and joyful Christmas season. A Merry Christmas to one and all.

Canadian Conference on Children

PEARL STIVER, our General Secretary, attended the Canadian Conference on Children which was held in St. Adele, P.Q. October 2-6. Miss Stiver presented a statement outlining the activities of nurses in the health, welfare and educational programs for children and youth. The CNA emphasized the comprehensive nature of nursing care and the availability of the nurse; pleaded for better utilization of nursing services in the interests of child care; asked for support of nursing education and nursing research programs which will ensure nursing services of high calibre in all aspects of child care; and stressed the need for a broader understanding of the contribution of the nurse, who by the very nature of her work touches all facets of child care.

ICN Congress

To attend an ICN Congress is a never-to-be forgotten experience. This is an opportunity which is ours only once every four years. The ICN's Twelfth Quadrennial Congress in Melbourne promises to be the biggest nursing Congress ever to be held in the Pacific area. Nurses from all parts of Canada have registered and will be making their way by ship or by air to Australia. It is not too late to register. Nurses planning to attend the Congress should apply for Application Forms to the CNA National office, 74 Stanley Avenue, Ottawa 2, Ontario.

CNA Publications

Reading the publications of your Association is the surest way to stay continuously up-to-date on the best of current thinking and practice in nursing. Information on these publications may be obtained from the Canadian Nurses' Association.

Homemaker Services

F. LILLIAN CAMPION, our Nursing Secretary, attended the National Conference on Homemaker Service held in New York October 12-14.

Discussion centred around the total needs of the family, how homemaker service can meet these needs; methods of establishing homemaker services in rural, country and urban settings; operation of homemaker services in social and health agencies; principles of interagency relationships; training and supervision of homemakers and financing of such services through public and private sources.

While in New York, Miss Campion visited with Miss HELEN MUSSALLEM who is attending Columbia University, to discuss plans for the implementation of the recommendations of the Pilot Project Report.

The Unusual

What would be unusual elsewhere becomes almost commonplace for public health nurses in Canada's northlands.

KATHLEEN DUFTON, a native of Radville, Sask., who recently completed a tour of duty in the Yukon, had to travel as much as 600 miles to care for some 3,000 people in her charge. When she visited Pelly River, the

only town in the district without a doctor, the hotel owner cleared out the beer parlor and turned it over to her for a clinic!

During the spring breakup, when roads were impassable, Miss Dufton had to travel by helicopter to Klondike City to visit native families stricken with influenza. Most of the time she travelled alone, advising the RCMP when she expected to arrive at her destination. If she was late, someone was ready to set out to meet her.

Northern Health Services supplied her with a car equipped with a sleeping bag, axe, tow chains, matches and emergency rations. "The coldest I have ever driven in was 52 below," she said. "I wouldn't start out in such a temperature. It so happens the cold spell set in while I was out so I kept moving."

Communities she covered included the mining towns and camps at Elsa Keno, Mayo Granville and riverside settlements such as Stewart Crossing and Pelly River. Twice a month she held a well-baby clinic in Dawson City, attending as many as 70 youngsters in an afternoon.

In Memoriam

Canadian nurses were shocked and saddened by the sudden death of **Gertrude M. Hall,** director of nursing, Calgary General Hospital on October 14, 1960. It was a tragic ending to what had begun as a happy occasion for the school of nursing. Graduation exercises, that had included a special presentation to Miss Hall, had just been concluded when death occurred. Thus came to an abrupt close a career of sincere, capable service on behalf of the nursing profession.

The years since her graduation from the Winnipeg General Hospital had encompassed an extensive variety of professional experience and activity. As a young public health nurse in Manitoba, she took charge of health services in Portage la Prairie; taught health education in Winnipeg's normal school and assisted the province's department of health by organizing various health services, surveying nursing homes and developing a nursing manual. Her interest in nursing education was particularly keen. Whenever the opportunity presented itself during these early years, she gave generous assistance to the provincial schools of nursing in their efforts to improve their programs.

Prior to Miss Hall's appointment as general secretary, Canadian Nurses' Association in 1944, she had served for four years as executive secretary and school of nursing advisor, Manitoba Association of Registered Nurses. During the following eight years, as she discharged the demanding duties of the national office, she found time to meet and talk with hundreds of hospital administrators and directors of nursing. Gradually, as she listened to them discuss their problems and plans she developed ideas of her own about the conduct of a school of nursing. The appointment as director of nursing, Calgary General Hospital, in 1952 gave her the chance to put her cherished dreams into action. Directors of nursing everywhere will appreciate the long hours of work, the problems, the triumphs, the failures and successes that have made up the past years. Although endowed with a tremendous capacity for work, the strain eventually proved too great.



GERTRUDE HALL

Many Canadian nurses will mourn her as a cheery, loving friend. The nursing profession in Canada has lost an able, devoted leader.

Florence (Easton) Anderson, a graduate of Royal Victoria Hospital, Montreal in 1908, died May 15, 1960.

* * *

Norma Anne (Babey) Cunliffe, a 1959 graduate of Moose Jaw Union Hospital, died in a highway accident during the summer of 1960. She had been on the staff of Lloydminster Union Hospital, Sask.

* * *

Gladys M. Dunn, an Ontario nurse, died during September, 1960 in Lindsay, Ont.

* * *

Mary Griffin, a 1911 graduate of Royal Victoria Hospital, Montreal died on February 11, 1960.

* * *

Eva Muriel Haliburton who graduated from Victoria General Hospital, Halifax in 1935 died on October 2, 1960. She had been director of the VGH outpatient department for 10 years. At the time of her death she was a staff nurse at the School for the Deaf, Halifax.

* * *

Elizabeth Hall, a member of the first graduating class of the Owen Sound General and Marine Hospital in 1903, died September 5, 1960. She was 91 years old.

* * *

Nora (Sinclair) Kavanagh who graduated from Royal Victoria Hospital, Montreal in 1927, died July 24, 1960.

Berthe Lapointe, a graduate of Hôpital Youville, Noranda, P.Q., in 1957 died as the result of an automobile accident during July, 1960.

* * *

Mary Hughena MacDonald, who graduated from St. Joseph's Hospital, Glace Bay, N.S. died on January 13, 1960. During a part of her professional career, she devoted much time to the sick and needy in areas of New York City.

* * *

Ethyle L. (McLeish) Mack who graduated from Penetanguishene General Hospital in 1916 died earlier this year in Orillia, Ont.

* * *

Hughena (Campbell) Murray, a graduate of Royal Victoria Hospital, Montreal in 1906, died June 1, 1960.

* * *

Loretta (Charland) Simpson who graduated from Montreal General Hospital, in 1927, died July 26, 1960 after a lengthy illness.

* * *

Eva Welch, a 1901 graduate of Royal Victoria Hospital, Montreal died July 29, 1960.

* * *

Lynne Whittaker who graduated from Royal Victoria Hospital, Montreal in 1955, died April 2, 1960.

There are Two Seas

There are two seas in Palestine. One is fresh and fish are in it. Splashes of green adorn its banks. Trees spread their branches over it, and stretch out their roots to sip of its healing water. Along its shores the children play.

The River Jordan makes this sea with sparkling water from the hills. So it laughs in the sunshine. And men build their houses near it, and birds make their nests; and every kind of life is happier because it is there.

The River Jordan flows on south into another sea. There is no splash of fish, no fluttering leaf, no song of birds, no children's laughter. Travelers choose another route unless on urgent business. The air hangs heavy about its waters and neither man nor beast nor fowl will drink. What makes this difference in these neighbor seas? Not the River Jordan. Not the soil in which they lie; nor the country round about.

This is the difference. The Sea of Galilee receives but does not keep the Jordan. For every drop that flows into it, another flows out. The giving and receiving go in equal measure. The other sea is shrewder, hoarding its income jealously. It will not be tempted into any generous impulse. Every drop it gets, it keeps. The Sea of Galilee gives and lives. The other sea gives nothing. It is named the Dead Sea.

There are two kinds of people in the world. There are two seas in Palestine.

— Bruce Barton

* * *

The word December has a Latin origin, from *decem* meaning tenth. The Roman year began in March making December the tenth month.

NURSING PROFILES

The board of directors of the International Council of Nurses has announced the appointment of **Helen Nussbaum** as general secretary designate. Miss Nussbaum will assume the full responsibilities of this position after the 1961 Quadrennial Congress.



(Nelly's)

HELEN NUSSBAUM

The ICN is the oldest and, in all probability, the largest organization of professional women in the world. The duties of general secretary are many and varied. Their successful fulfillment requires comprehensive experience of nursing on a world-wide scale. This Miss Nussbaum offers in abundance. Born in Sicily of Swiss and British parentage, she eventually obtained her professional preparation in Italy, England and Switzerland. The war years, 1941-45, were spent in district nursing in Switzerland. In 1946 she was recruited by UNRRA for a tour of duty in Greece. After the withdrawal of this organization, Miss Nussbaum remained in the country under the auspices of WHO as a tuberculosis supervisor in liaison with the ministry of health, Athens. In addition to her duties in this area, she opened and directed the first school for nursing aides in Greece.

After completing her assignment with WHO, she undertook a special health mission in the Greek prisons as a member of the International Committee of the Red Cross. Later, as a delegate of ICRC, she was called upon to take part in the relief work required in the Ionian Islands following an earthquake. A year at the organization's Geneva headquarters as deputy chief nurse was succeeded by yet another tour of duty in Greece. On this occasion Miss Nussbaum developed a centre to care for homeless and unwanted babies. She also organized the first school for nursery nurses in the country.

In 1958 she returned to Switzerland as executive secretary of the Swiss Nurses' Association. Many visitors had reason to appreciate her careful planning and generous courtesy. Her fluency in several languages was a great asset in carrying out these duties as it will be in her present role.

Canadian nurses join with their colleagues the world over in welcoming Miss Nussbaum to her new position and extending sincere good wishes for her future happiness and success.

Laura Winifred Barr, has joined the provincial office staff, RNAO, as assistant executive secretary. During the past four years she had been on the staff of the Metropolitan General Hospital, Windsor, first as associate director in nursing service and latterly as director of nursing education. She had previously served as instructor in nursing, Grace Hospital, Windsor and as a clinic nurse.

Born in Japan of missionary parents, Miss Barr completed her basic education in Toronto and entered Grace Hospital, Windsor for her nurses' training, graduating in 1948. She holds her certificate in nursing education from the University of Toronto. She has been an active participant in the activities of the Windsor-Essex chapter, RNAO, and of the district organization. Travel, cooking and membership in the Business and Professional Women's Club occupy spare moments.

Mary O'Brien, the new director of nursing, Grace Dart Hospital, Montreal, is a graduate of Royal Berkshire Hospital, Reading, Oxford City Isolation Hospital, England, and Glasgow Western Hospital where she completed qualifications as a state certified midwife. She is admirably qualified for her present duties, having had particularly intensive training in tubercular work in Scotland. She participated actively

in the public relations campaign that preceded the City of Glasgow's mass radiography drive. This project served as a pilot study for similar campaigns in other areas. Miss O'Brien has also had training in various specific areas of tuberculosis treatment such as the use of longterm chemotherapy, domiciliary care, cortisone and collapse therapy.



(Geraldine Carpenter)

MARY O'BRIEN

Since coming to Canada in 1957, Miss O'Brien has undertaken university study towards her arts degree. She enjoys golf, tennis and travelling, her ambition in respect to the latter interest is to see as much of this continent as possible.

Fernande Riverin was recently named assistant director of nursing, Grace Dart Hospital, Montreal. Following graduation in 1939 from Hôpital St-Jean-de-Dieu, she took postgraduate study in psychiatry at the same institution. Her aptitude in this field led to further study at the Centre international de l'Enfance, Paris, and Catholic University, Washington.

Her experience has been varied, ranging from institutional nursing to occupational therapy and, latterly, to supervision of affiliating students at St. Jean de Dieu.

Active in nursing organizations, Miss Riverin is president of her hospital's alumnae association, corresponding secretary and councillor of the Montreal division, Catholic Nurses' Association. Reading, travel and writing are favorite leisure time hobbies.

Mary Elizabeth Macfarland, director of nurses at Toronto General Hospital since 1942 has announced her retirement. A graduate of TGH with her certificate in teaching and supervision from the University of Toronto, Miss Macfarland has given long and devoted service to her alma mater. After several years as head nurse of the gynecological ward, she became supervisor and instructor of the medical division following her university experience before succeeding to the position from which she has retired.

Her contribution to the life of various professional organizations has been equally outstanding. She is a life member and past president of her alumnae association; a member of the nursing committee, Ontario division of the Canadian Red Cross Society; a member of the advisory committee for the school of nursing, University of Western Ontario.



MARY MACFARLAND

Under her capable guidance the nursing department of TGH has made noteworthy progress. Her personal loyalty, integrity and devotion to her hospital influenced the lives, both personal and professional, of the many nurses with whom she came into contact.

In the eighth century the Germans introduced the custom of the Christmas tree and many years later Martin Luther lighted it with candles.

The Christmas card was introduced in England around 1840. As late as 1900, Christmas cards were delivered personally, with a calling card.

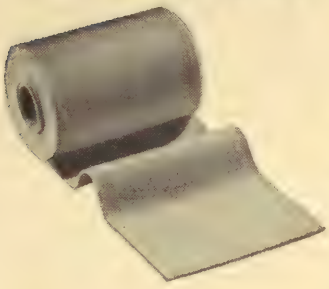
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The Selection of Learning Experiences

FLORENCE E. ELLIOTT

To assist schools of nursing in upgrading their educational programs, the CNA has been working towards the development of a curriculum guide. This is the third of a series of four articles on this topic.

THE PRESENT GENERALLY accepted definition for a curriculum ackowledges that it goes beyond subject matter content to include all of the learning experiences that are planned and controlled by a school.

This modern concept of curriculum has particular significance for nursing education. A far too common feature in schools of nursing is the educational program that has two rather separate parts: 1. Those experiences that are carefully planned and controlled by the faculty, and 2. another whole set that can be called "learning experiences" only by virtue of the fact that every experience that we have contributes to our learning. The faculty plans only very sketchily for the latter and control lies with another group. The term *learning experience* is used to refer to any event that is planned to assist the student to achieve the objectives of the curriculum. Such experience, in accordance with this definition goes beyond the care of patients to include formal classroom presentations, patient-centered conferences and student-instructor conferences.

Perhaps it would be well to consider the process of curriculum development as *curriculum building*. This provides a mental picture of the curriculum as a pyramid. Its apex is the purpose of the school. Supporting the apex are the objectives of the curriculum. These in turn are supported by the individual course objectives, all of which contribute their share in the achievement of the curriculum objectives. At the base of the pyramid are the learning experiences designed to achieve the course objectives. The mortar that holds the bricks of this structure together is the school's philosophy of nursing and nursing education.

Miss Elliott is the director of the study on cost of nursing education with the National League for Nursing. She presented this paper at the Curriculum Workshop, Canadian Nurses' Association in 1959.

Criteria for Selection

How do we select learning experiences? Each one should be chosen for its worth in achieving specific educational objectives. Faculty members must be prepared to answer the questions, "What is the educational outcome expected?" and, "For what purpose is this experience planned?" in relation to each experience that is included as a part of the program. We should select experiences in terms of what we know about the learning process. Here we utilize the data accumulated by research in the field of educational psychology.

1. *Individuals learn most effectively when they are interested.* This reminds us that the student will benefit most from an experience which she recognizes as contributing something of value to her own goals. For her as well as for the instructor there is a good reason for the experience. As instructors, we cannot impose *our* goals on the student. We are most successful when we capitalize on the student's interests and help her to develop worthwhile objectives for herself.

2. *Learning depends on what one wants to learn.* An individual learns best when he is free to create his own responses to a situation. Are we able to create a student-teacher relationship that is based on mutual respect and permits the student to find the answers in her own way? Does the student feel free to respond spontaneously? Does the student feel comfortable enough with the instructor to react naturally or does she perform in the way that she knows is expected? Does our system create tensions or pressures that seriously re-

strict the amount of learning that takes place?

3. *Learning depends on not knowing the answers and finding them.* Students must be encouraged to raise their own questions. They should be guided to *find* answers in preference to being *given* answers. A serious limitation of the lecture method is that the subsequent regurgitation of facts by the student may very well mean that she may not recognize what she does not know. Learning experiences should be planned so that the student is helped to see the application of scientific principles to nursing situations; to analyze and examine nursing situations in the light of her theoretical knowledge; to select the principles that she believes apply to the specific situation and to try them out.

4. *Learning is largely a behavioral experience.* To learn is to change. The teacher cannot *give* learning to students. Is this not particularly significant in nursing education where a thorough knowledge of facts alone does not mean that an individual will be effective in nursing practice?

Self-activity is necessary for learning to take place. A student should have learning experiences that provide an opportunity to practise the kind of behavior required by the stated objectives. Repetitive activity is not sufficient. The activity must be related to the goal and the student must see the relationship. Learning is developmental. Learning experiences should be organized in a continuum so that each new experience reinforces the previous one. There should be an orderly arrangement with progression from the simple to the complex and with a reasonable distribution and balance throughout the program.

Bronchogenic Carcinoma

Mona Eisenstat

Because lung cancer incidence is increasing and there are no strongly suggestive symptoms which might bring the patient to the doctor, nurses will care for an increasing number of patients who are in the advanced, inoperable stage of this disease.

Incidence

Bronchogenic carcinoma accounts for 5 to 10 per cent of all cancer deaths.[3] It is the most common cancer site among men over the age of 45 and six times more frequent in men than in women.

Location

Tumors develop in the mucosa of a broncus, usually in the upper lobes. Many, if not all of them, pass through an apparently benign stage. These benign adenoma of the bronchus must be considered premalignant. As they grow, most of them cause obstruction, sometimes with secondary bronchiectasis and lung abscess. (Bronchiectasis is a chronic disease of the bronchi characterized by dilatation of the tubes associated with changes in the walls, favoring chronic suppuration.) The tumors infiltrate the surrounding lung tissue, causing irregular areas of consolidation. Sometimes they cause pleural effusions, which are frequently bloody and contain tumor cells that may be identified in the centrifuged sediment from the fluid.[3]

Symptoms

The growth of new cells produces bronchial narrowing and eventually a cough with dyspnea develops. The symptoms depend upon the size and location of the new growth. If it is small and located in the main bronchus, there may be a cough. If it is in a

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Miss Eisenstat who is a student at the Jewish General Hospital in Montreal, was awarded honorable mention for this study in the recent Macmillan Award competition.

small bronchus in the periphery of the lung, it may grow to a considerable size before producing symptoms. Hemoptysis (spitting up of blood) may be the first symptom and can lead to an investigation which reveals the cancerous lesion.

Causes

The cause of cancer of the lung is unknown but it is believed that chronic irritation contributes to its development. Occupations in which the workers are exposed to radioactive substances or to certain chemicals are felt to be of significance. A history of heavy smoking is common and it is thought that this may be a factor contributing to the disease.[4]

Types

There are three pathological types of bronchogenic carcinoma:

1. Epidermoid or squamous cell carcinoma.
2. Adenocarcinoma.
3. Oat cell carcinoma.

The first two originate in the bronchi or bronchioles. The latter is thought to originate in the alveoli. It is the epidermoid or squamous cell type of carcinoma that is showing an increased incidence.

Course of the Disease

Metastases occur to the mediastinal and cervical lymph nodes, the walls of the esophagus, the pericardium and the opposite lung. Advanced cancer of the lung causes marked dyspnea with wheezing, weakness, loss of weight and appetite, cough and pain.

Bronchogenic carcinoma gives rise to lymphatic metastases early in the course of the disease. From the involved bronchial and mediastinal lymph nodes further extension soon occurs, both upward to the supraclavicular nodes and downward to nodes around the abdominal aorta — thence to the liver and adrenal glands. Dissemination by the blood stream is frequent, so that brain metastases are prone to occur.[1]

Suffering in the terminal stages is often extreme. At times, the course of illness appears very slow and the patient's life is made miserable for months by severe pain, dyspnea, harassing cough and foul sputum. Uncontrollable hiccoughs, alarming hemorrhages, headache and loss of vision due to cerebral metastases are typical sequelae that combine to make the patient's existance intolerable.

Treatment

As both the public and physicians become more cancer conscious, an increasing number of cases are diagnosed early and the patients saved by lobectomy or pneumonectomy.

X-ray treatment may be helpful but is not curative. The objective of radiation therapy is to deliver a lethal dose to malignant cells and at the same time limit injury to normal tissue. Whenever radiation is used extensively, radiation sickness may occur. This condition, according to present theory, is brought about by the liberation of the products of protein decomposition due to the death of a large number of cells at one time. The major symptoms of radiation sickness are: anorexia, nausea, vomiting and mental depression.

If the tumor is very extensive, the mediastinal glands involved, a gangrenous pleural effusion has formed, or if metastases have become established the disease is generally inoperable. Treatment is then syptomatic, aiming at keeping the patient as comfortable and free from pain as possible.[3]

The Patient — Social History

Born in Poland in 1907, Mr. Mendel migrated to Montreal at the age of 18. He cannot write or read any language but can speak five languages fairly well.

He worked at odd jobs for the first few years and then started a "junk" business with his father. He met his wife when he was in his early twenties and they had a most happy marriage. He has two sons who are now in their twenties. Tragedy struck two years ago when Mrs. Mendel passed away after a long illness. Her death at a convalescent home occurred while Mr. Mendel was hospitalized and he discharged himself to attend the funeral. He had been taking care of her prior to his admission to hospital. His business had been neglected.

The family finances were very meagre. His younger son had had a "nervous breakdown" due to his mother's death and his older son, a taxi driver, had only a small income. The younger son, who is very devoted to his ill father, cannot

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keep a job for any length of time. The older son has a wife and family to support in addition to helping his father, younger brother and 80-year-old grandfather.

Prior to Mr. Mendel's illness, he was a very strong, independent fellow weighing over 200 pounds. Although he never had much money, he managed to maintain a comfortable home. There was a very close relationship between the members of this family. Now, two years later, Mr. Mendel weighs less than 100 pounds and is a very nervous, irritable and demanding man who cannot accept his illness. He has not been told that he has cancer; he thinks that he has had a benign tumor removed and that there is now an "inflammation" in his chest. His immediate family know the diagnosis and the probable outcome of the disease.

Mr. Mendel is Hebrew, but is not religious and does not care to discuss it. It is interesting to note that he has smoked three packages of cigarettes a day for the past 25 years.

Previous Admissions

Mr. Mendel was never seriously ill prior to his first admission to hospital in the spring of 1957. He had had a cold which lingered for some time and consulted a doctor who admitted him for further investigation. A diagnosis of bronchogenic carcinoma of the left lung was made and a left pneumonectomy was performed.

Pneumonectomy is the removal of an entire lung. The nature of the disease and the extent of the lung involvement may make surgery difficult. A posteriolateral thoracotomy incision with resection of the third or fourth rib is made. The pulmonary artery and vein are ligated and divided; the main branches are resected, closed and covered with adjacent tissue. The phrenic nerve is crushed to allow the diaphragm to rise on the affected side and thus obliterate the cavity which remains following removal of the lung.

After an antibiotic solution is injected into the cavity, the incision is closed without drainage tubes. The cavity is smaller than normal because of the elevation of the diaphragm on the operative side and the slight shifting of the mediastinum. Normal negative pressure found in the chest draws fluid into the cavity from the surrounding tissues. This fluid becomes incorporated with red and white blood cells and eventually a cheese-like material forms and fills the space preventing the other lung and the heart from shifting toward the affected side.[5]

The patient felt fairly well after the operation. He was discharged in two months and returned frequently to the clinic. The wound did not heal properly and two months after discharge he was readmitted because empyema had developed (empyema is pus in the pleural cavity). A rib resection and drainage was done and the patient was discharged with a Pezzer catheter in his left hemithorax. Four months later it was removed, but soon had to be reinserted.

Mr. Mendel was readmitted for the fifth time for residual empyema and emphysema (the alveoli lose their elasticity and become distended). The social service department arranged for him to convalesce at a sanitorium in the country. However, in two weeks he was returned to the hospital by ambulance.

Present Illness

While at the convalescent hospital, Mr. Mendel had been coughing and spitting small amounts of blood. His hemoglobin had fallen to 60 per cent. Two blood transfusions were given raising his hemoglobin to over 75 per cent.

An examination of his chest revealed the presence of a large pleural effusion on the left side. The left diaphragm appeared quite elevated with many distended loops of bowel beneath it.

A bronchoscopy was done. A bleeding site was noted at the stump of the left bronchus. His left vocal cord was found to be completely paralyzed, his right cord normal. Mr. Mendel has a hoarse voice and whispers.

An x-ray of the lumbo-sacral spine revealed a scoliosis to the left, but no definite destructive lesion.

Mr. Mendel complained constantly of pain in his legs, especially the left — sometimes so severe that he would sob for hours. He received various medications for the pain, given every four hours whenever necessary, but he would cry for an injection or pill after two or three hours, especially during his last weeks in hospital.

Nursing Care

Mr. Mendel refused to get out of bed even though the doctors urged that he should. He remained on his right side day and night so that even making his bed presented a problem. He was very jealous and demanding. If the patient in the next bed asked for something while Mr. Mendel's back was being rubbed he would say "She has to finish with me first. Everyone always disturbs me when I am being cared for. Wait your turn." He was rude and unreasonable at times, but his illness and suffering explained his actions.

At times, the patient would become quite depressed and ponder doubtfully about his recovery. He did not try to put on a good front for his family. He cried when they came and they would share his misery with him. His sister and his sons felt very inadequate because there was nothing they could do to lessen his suffering.

In addition to drugs Mr. Mendel received 20 Cobalt 60 treatments. The nurse can do much to aid in overcoming the patient's fear of the treatments by assuring him that although he may have some discomfort from them it rarely lasts more than a few hours and the doctors will order medicine to stop most of the symptoms. Mr. Mendel was carefully informed about the therapy. He was told that he would be placed in a room by himself but that there would be a radiotherapist outside the room all the time with whom he could communicate. It was explained that the equipment was similar to what he had seen during routine x-rays. He was informed that one day he would receive the treatment on his chest and the next day on his back. He did not fear the actual treatments but dreaded the after effects. When he learned that the medications would prevent him from vomiting he was more at ease.

Routine physical care was given in addition to special back care. Normal tissue reacts to the radiation treatment and great care must be taken of the skin. No soap or alcohol was used on the treated area, nor was it washed vigorously or massaged. No adhesive tape was used on his back or chest during the period of therapy as it interferes with the rays and the skin is hypersensitive to it.

During the long course of radiation the patient may need supplementary drugs to aid in maintaining adequate nutrition. Mr. Mendel received Vitamin B_{12} 1000 mg. intramuscularly twice a day. He was on a regular diet but his appetite was poor except at breakfast time when he would eat everything.

Discharge Plans

The social service department arranged for Mr. Mendel to be discharged to a convalescent home. The city will pay his expenses. For the first two weeks he really enjoyed being there. Now, a month later, he is complaining that he needs to be in the hospital. His hopes of recovery are gone and he no longer thinks about spending the summer in the mountains with his father.

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School of Nursing University of Ottawa

At sundown on December 25th, Jews throughout the world will start celebrating the first day of Hannukah, the Feast of Dedication. This festival was instituted by Judas Maccabaeus in 165 B.C. to celebrate the purification of the Temple of Jerusalem, which had been desecrated by Antiochus Epiphanes. Also called the Festival of Lights, the feast lasts eight days. One light is kindled on the first night and an extra one added on each successive night. Hannukah represents a time of good fellowship, family gathering, the exchange of presents and merrymaking.

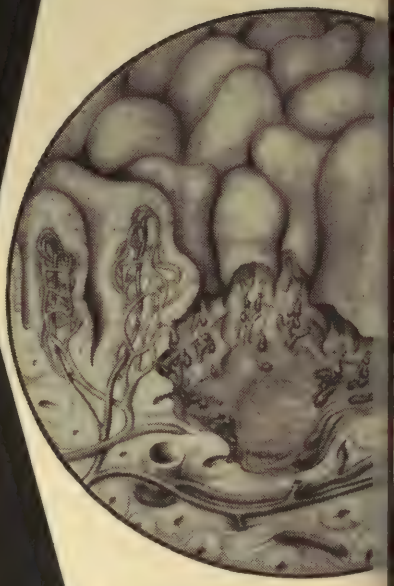
— *The Bulletin,* Vol. 38, No. 12

* * *

Don't let your job become monotonous; think up ways to improve routine work.

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in internal bleeding



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in duodenal ulcer

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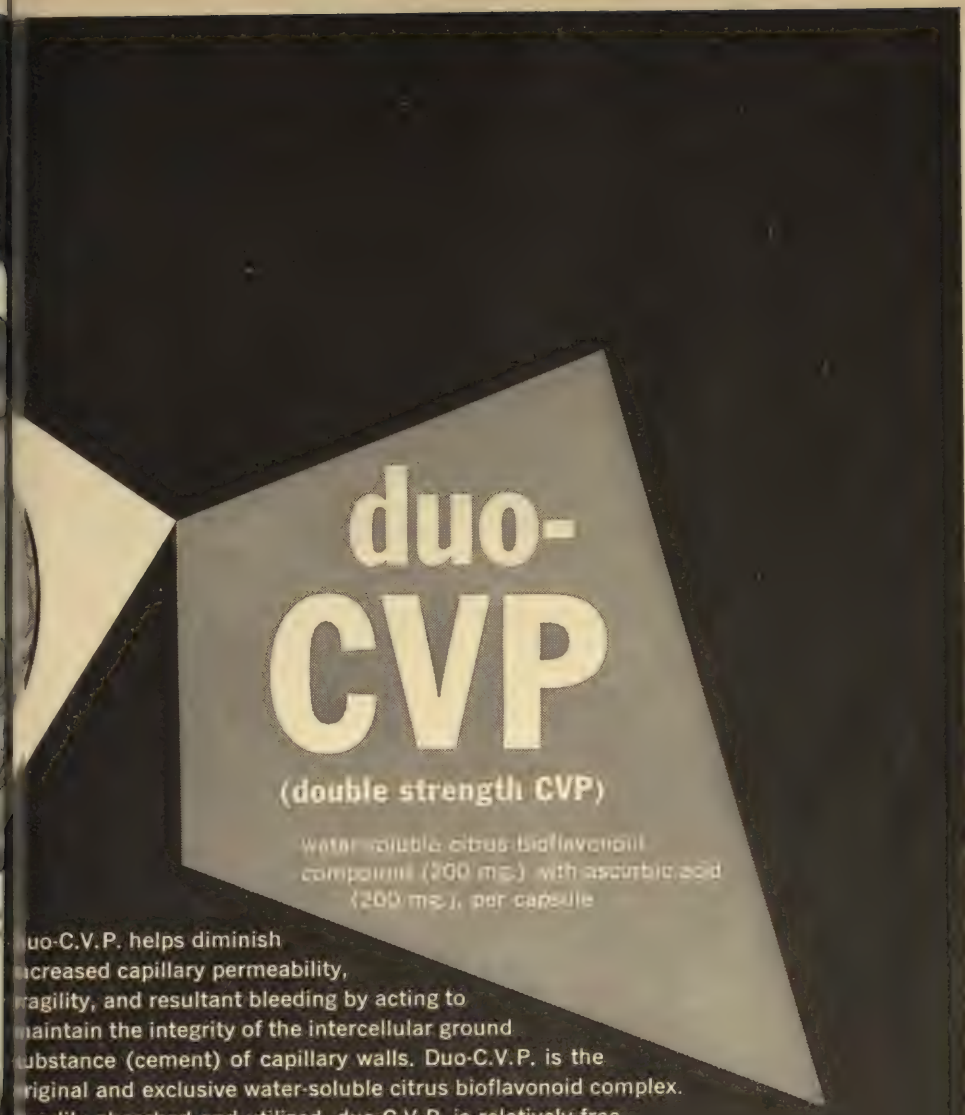
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Two Degrees above the Equator

Sister Mary Frances Xavier, o.l.m., S.C.M.

With world-wide attention focused on Africa and on Nigeria, as the final steps were completed to proclaim independence on October 1, 1960, readers may be interested in knowing something about nursing, two degrees above the equator.

Canadian nurses, like good citizens, are at home anywhere in the world — whether it be working in a Red Cross outpost in the frozen wastes of the far north; supervising a hospital in one of Europe's refugee camps; or driving along a bush path, almost hidden by mango trees and thick foliage, en route to a native village for dispensary work in tropical Africa. Wherever she is, the Canadian nurse practises a high standard of nursing care.

The northern region of Nigeria, has a population of approximately 33,000,000, mainly composed of Moslems. The vast majority of the people are uneducated. Native doctors practise their arts often with disastrous results. Ju Ju, a belief in native witchcraft, is followed by the majority, and "white man's medicine" is regarded with suspicion. It is not uncommon to see a small child wearing around his neck a multitude of trinkets, bells, and crocodile teeth to "keep the evil spirits away and make the baby strong."

There are four Canadian nurses from a religious order working in Okene, in Kabba Province. The town has 140,000 people and is situated near the boundary of the northern region. A new 120-bed general hospital is under construction. At the present time there is accommodation for 75 patients. Eventually, the hospital will have a school to train the Nigerian girls. An Italian doctor is in charge of the hospital. He and his wife, who is a pharmacist, work untiringly for the benefit of the people. Although supplies and medical equipment are limited and working conditions difficult, the doctor has endeared himself to his patients. It is particularly in the field of obstetrics and gynecology that medical aid is so invaluable.

A few months ago a young woman, Amanatu, was brought to us almost unconscious. She had been literally "dropped off on us" by a passing truck. Her condition was fair, pulse 100, a full-term pregnancy with the caput present on the perineum. She was a primipara and had been in labor for four days with many native doctors in attendance. It was apparent that operative delivery would be necessary.

Amanatu was transferred to the delivery room and routine admission treatment given. Her blood pressure was 90/50; temperature 100° F.; pulse 100; respirations 20. Abdominal palpation revealed a fundus at the level of a 40-week pregnancy. The fetus was in the L.O.A. position, the head was not engaged. The fetal heart was not heard. The mother was prepared for a forceps delivery. Morphia gr. ⅙ was given subcutaneously. Upon vaginal examination it was discovered that Amanatu had a contracted pelvis.

If undiagnosed, a contracted pelvis will give rise to prolonged, difficult and obstructed labor. This may result in injury or death of mother and child. A pelvis is contracted when one or more diameters are over one centimetre less than the minimum normal range, thereby making the delivery of an average-sized baby by the natural route difficult or impossible. Female pelves have been classified by Caldwell and Moloy into four basic types each one is designated according to the shape of the brim. The differences in shape are thought to be due to racial and familial inherited characteristics or to endocrine influence, but not to disease.

Amanatu had a justo-minor or gen-

Sister Mary Frances Xavier, a graduate of Hotel Dieu Hospital, Cornwall, Ont., is a member of a Canadian order of religious sisters devoted to medical and teaching work in foreign lands. At present she is stationed in Nigeria.

erally contracted pelvis with cephalopelvic disproportion.

A symphysiotomy was done. This is not a popular procedure in Canada where Caesarean section is the method of choice. It is carried out in Europe in selected cases and excellent results are obtained. The operation consists of an incision, under local anesthetic, through the abdominal wall. Then the symphysis pubis is divided. This gives the pelvis approximately one-half an inch increase in diameter. A bilateral episiotomy was made, but as there was still a slight contraction it was necessary to do a craniotomy on the baby. She was delivered of a dead child.

Due to shock and blood loss, Amanatu's blood pressure was 70/50; pulse 160; respirations shallow. Coramine 2 cc. was given intramuscularly. An intravenous solution of 1000 cc. 5 per cent glucose and saline was begun, while the episiotomy and symphysiotomy were being sutured. Later, the patient was transferred to the maternity ward and the foot of her bed was placed on blocks in shock position. A second bottle of 1000 cc. 5 per cent glucose and saline was given and another injection of Coramine 2 cc. A Foley catheter was inserted. The doctor left orders for antibiotic therapy and administration of Stilbestrol. Amanatu's condition improved quickly and she spent a comfortable night.

Nursing care consisted of a daily bed bath and routine perineal care. Acroflavin compresses were ordered to be applied to the perineum, which was very edematous. Amanatu was instructed to do deep breathing exercises to prevent hypostatic pneumonia. Particular care was taken to posture the patient with her legs together in order that the bones of the symphysis pubis would unite in correct alignment.

On her third day postpartum, the Foley catheter was removed and Amanatu voided normally. A tight binder was applied to her breasts. On the seventh day she sat on the side of the bed. Two days later she was able to be up and walking. The symphysiotomy incision was completely healed. No deformity in gait was noticeable.

Amanatu was instructed about the importance of antenatal care, and of regular attendance at the hospital clinic during any future pregnancy so that abnormalities might be detected. She was advised, also, that Caesarean section would be a necessity due to her contracted pelvis. Her diet was discussed and she was taught how to include adequate protein, especially in the form of liver and eggs. Most of the diets of the people in this area are deficient in protein, which causes a form of anemia. They also lack vitamin B which leads, in severe cases, to beriberi and subsequent heart damage.

Amanatu was discharged on her 16th day in excellent health. She was anxious to return to her native village and to her own compound. Many maternal deaths could be prevented in Africa by good antenatal care. We hope that Amanatu will prove an effective public relations agent for the hospital and direct many women to the clinic.

Parents beware! Holiday decorations are potentially toxic.

The bright colors, movement and light of bubbling Xmas tree lights make them particularly alluring to small children. Small amounts of the fluid, when ingested, will cause CNS depression, but large amounts may cause late liver and kidney damage.

Inhalation of snow sprays may result in foreign-body irritation in the lungs. Watch for signs of aspiration pneumonia.

The metallic salts that cause multi-colored flames when thrown in the fireplace, will cause intense gastrointestinal irritation if ingested. If the trade name of the salt is known a specific antidote may be prescribed; otherwise emesis should be induced by administration of a demulcent.

The berries of holly and mistletoe are both toxic. Treatment following ingestion consists of inducing vomiting.

Prevention can avert tragedy.

— *Hospitals*, Vol. 33, No. 24.

* * *

To iron puffed sleeves and to get at hard places, fold a heavy wash cloth over the fingers and insert them under the surface.

— *Alumnae News*, Hotel Dieu of St. Joseph, Windsor.

CEREBRAL PALSY

MARILYN SPICER

It is easier for parents to do for a child with cerebral palsy than to help him to do for himself. They need as much patience and understanding from the nurse as they in turn will need in the care of their child.

Cerebral palsy occurs in three different forms:

1. *Spastic:* The child has suffered damage to the motor area of his brain, the part that translates desire into action. His muscles are tense and contracted, pulling and twisting his face, arms, legs and body.

2. *Athetoid:* The damage is in the brain stem. It accounts for the second largest group of cerebral palsy victims. The muscles affected are in continual, purposeless motion and cannot be directed into organized action. Athetoid children have been called "prisoners within a framework of constant unwanted motion."

3. *Ataxic*: This group represents a small percentage of cerebral palsy children. This child walks with a staggering gait which gives him a very clumsy appearance.

A child with cerebral palsy may have a combination of types but usually one type predominates.

Cerebral palsy is not a disease. It is an abnormality caused by injury to the unborn child either during pregnancy or at delivery. It can be caused by a disease such as meningitis following birth. Cerebral palsy is not hereditary. It is no reflection on the physical or mental health of the parents.

A cerebral palsy child is an individual, with the same needs and fears as a normal child. He does not notice that he is different from others until he becomes older. Then he may become very frustrated because he cannot do tasks with the same speed and confidence that others can. He cannot play on an equal basis with other children. Because of his clumsy movements and persistent drooling, many people mistake him for a mentally retarded child. Actually, most of these children are perfectly normal in their thinking. However, it is true that some of them have brain damage and are mentally retarded.

Although the majority of these children cannot converse intelligently, they understand others well. They learn at their own pace — usually very slowly — and must be encouraged to do so. However, they must not be babied or overprotected. They should never be laughed at or ridiculed since they are very sensitive. Cerebral palsy children can be helped. Parents should not give up hope or faith. If they accept the child with love and understanding, he will be more easily accepted in the community. Most people have some handicap and cerebral palsy is only one of the many. Sometime in the near future, a successful treatment may be found.

Miss Spicer wrote this study during her senior student year in the school of nursing, Civic Hospital, Peterborough, Ont.

Diane's Story

Diane, a pretty little blond-haired girl, was affected with cerebral palsy. Her father worked as a mechanic in a local factory and provided a steady income for his family. Both he and his wife are Canadian-born. The family live in a four-roomed frame house. Their home is neat, clean and tidy with a pleasant atmosphere. The family live moderately well and seem quite happy together.

Diane was born five years ago in a local hospital after a normal, full term pregnancy. However, the mother's labor was long and the baby was delivered instrumentally in a face presentation. She appeared to be normal and weighed seven pounds and fourteen ounces. At the age of five months, she cut her first tooth. At six months she started her immunization program. At eight months she was unable to sit unsupported, and her head fell forward.

The public health nurse visited the



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1. A.M.A. Journal of Diseases of Children 95: 109-119, 1958
2. Publication 589, National Academy of Sciences, National Research Council

home shortly after Diane's birth to see if she could help the mother in any way. She found her interested and cooperative. The following spring the nurse again visited the family. She noticed that Diane did not have full use of her right arm and leg; that she did not sit alone and that she was unable to hold her head upright. Her right thumb was folded into the palm of her right hand. She had some weakness of her eyes. However, the pediatrician felt that nothing could be done at that time.

Diane was admitted to a children's hospital on three occasions within three months. Investigation revealed that she was reasonably alert mentally although she had left-sided brain damage. It was observed that her right calf muscles were taut and that she would bear weight on her right toes only, when walking. She had spasms of falling forward (as many as 12 falls in succession). Sudden convulsive twitchings of her body were noticed occasionally. She was given a compound of dilantin and her convulsive disorder became less pronounced. The need to strengthen her back and neck muscles was stressed. A return visit to hospital was for this purpose.

Diane's parents were visited again by the public health nurse who suggested the groups available in the community where they could receive necessary assistance. They were urged not to become slaves to their daughter but to let her lead as normal a life as circumstances allowed. Diane's progress was fairly satisfactory for the next two years. Petit mal seizures were no longer troublesome. She was holding her head upright and seemed to notice what was going on about her. Her left eye tended to turn inwards when she was tired. Growth of her right side appeared normal. Her mother seemed very interested in the suggestions made by the nurse to help the child. She was referred to the Crippled Children's Society for help.

The nurse discovered that Diane was being fed by her mother. The importance of providing opportunities for learning was again stressed. About six months later Diane was still being fed and independent feeding methods were discussed. The nurse was unable to convince the mother that she could do much more for her daughter by giving her a chance to do things for herself.

Not much improvement has been made in recent months. However, Diane walks for short distances and is bearing weight on her good left side. She walks on the toes of her right foot. She is still being fed by her mother. She has a high shrill cry and has been taking 10-15 petit mal seizures daily. She shows great affection at intervals but does not appear to comprehend words. Music interests her and she listens to it contentedly.

The nurse has constantly and repeatedly suggested ways to help Diane and her parents. This advice has apparently been given in vain. The parents are interested in their child's welfare but will not accept her abnormality as part of their daughter's life. They also lack the initiative to help Diane to help herself. In years to come, Diane may become a great burden to her parents as a result.

Mistletoe is a parasitic, evergreen plant which grows on many trees, especially on the oak and the cypress. In olden times the Druids regarded it with great veneration. The priests gathered the plant with a golden knife on the sixth day after the first new moon of each year. They divided it with ceremony and distributed it to the people who wore it as a charm to ward off evil.

— *New Educator Encyclopedia*, 6:2371

* * *

Under the influence of St. Francis of Assisi in the 13th century, Christmas carols evolved into their present form.

The poinsettia was discovered in Mexico in 1828 by Dr. Joel Poinsett, the first U.S. minister to that country. There, it was called Flor de la Noche Buena (Flower of the Holy Night) with its legendary origin being from the drops of blood that fell from the broken hearts of maidens disappointed in love.

— *American Practitioner* Vol. 10, No. 12

* * *

At Christmas I no more desire a rose
Than wish a snow in May's new-fangled mirth;
But like of each thing that in season grows.

— *Love's Labour Lost*, SHAKESPEARE

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soothes irritation • quiets the cough reflex decongests nasal mucosa • facilitates expec-oration • decreases bronchial spasm • and astes good, too.

Each fluidounce of AMBENYL EXPECTORANT contains:

Ambodryl* hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
Benadryl* hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	56 mg.
Dihydrocodeinone bitartrate	⅙ gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied: Bottles of 16 ounces and ½ gallon.

Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children ½ to 1 teaspoonful. 27160

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FRACTURE OF THE MANDIBLE

CAROLE (ELDRIDGE) STEVENS

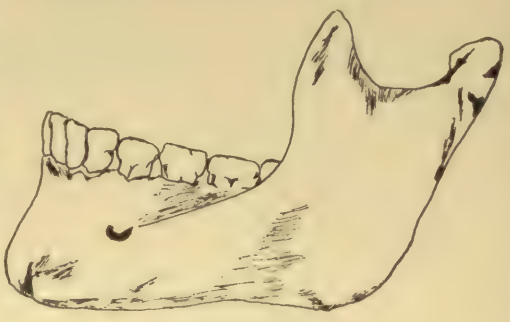
Although recovery from an injury such as this can be relatively uncomplicated, there are various emotional and psychological aspects to be considered as well as possible physical problems. It should not be dismissed as a minor condition requiring a minimum of nursing attention.

Facial Injuries in General

IN THE PAST FEW YEARS the number and speed of cars on our highways has been steadily increasing and there has been a proportional rise in the incidence and severity of facial injuries as a result of accidents. In the treatment of these cases doctors and nurses must recognize the importance of good cosmetic results. These patients have a very real fear that the damage will be irreparable. Apart from the need for good surgical and medical care, so that scarring and deformity is minimized, patients with facial injuries require constant reassurance and psychological support. They need understanding help in adjusting, and accepting the situation.

The Mandible

This is a single symmetrical bone forming the inferior anterior portion of the facial skull. It is the only bone in the skull that is movable. It consists of a convex body or *corpus* which forms the chin and supports the teeth, and a broad plate on each side called a *ramus* which projects backward and upward forming two processes. The posterior one articulates with the mandibular fossa of the temporal bone. This joint allows many varied movements of the jaw: elevation, depression, extension, retraction, side to side, and a combination of all these to give the gliding motion necessary for mastication. The jaw consists of a U-shaped cortical or outside layer of hard bone and an inner layer of softer cancellated bone. The blood supply arrives via the mandibular artery, and motor and sensory nerve impulses are supplied by the trigeminal or fifth cranial nerve.



The Mandible

Due to its exposed position the mandible is fractured more often than any other facial bone. The cause of fracture is usually a hard blow.

Symptoms of a Mandibular Fracture:

1. pain and tenderness — aggravated by movement
2. deformity — due to the direction of force, gravity, or muscle pull
3. swelling
4. abnormal motility — due to break in bone continuity, loose teeth
5. discoloration — due to effused blood
6. interference with chewing — teeth are out of line
7. crepitus — grating of bone when broken edges meet
8. possible gum laceration at the fracture site.

Diagnosis is made by signs, symptoms and x-ray confirmation which gives the direction, type, and severity of the fracture. Treatment is aimed at restoring normal position of the segments and fixation of them until union takes place. The principal guide for positioning is the relationship of the upper teeth to the lower, and of both sets to the oral cavity. The surgeon must have an accurate knowledge of this relationship so that proper occlu-

Mrs. Stevens who very recently graduated from the Royal Columbian Hospital, New Westminster received Honorable Mention for this study in the Macmillan Award competition.

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1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

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sion and mastication may take place after the fracture has healed. The length of time until union occurs depends on the number and character of fractures and the reparative powers of the individual. The average is three to five weeks if there is no suppuration or bone loss. Good oral hygiene during this period is a must if infection is to be avoided and primary healing to take place.

Introducing the Patient

Mrs. Peel was a short, slight, rather nervous woman who had completed grade eight education before her marriage. Twelve years ago she moved to the West coast with her family — a daughter, now 21 years old, who was married three years ago, and a 13-year-old son who suffered from nephrosis and had lost three years of schooling as a result.

The patient had never been in very good health. She had had three attacks of rheumatic fever at 10, 24 and 25 years of age — one of which was complicated by scarlet fever. Two years ago she underwent abdominal surgery. She and her son are under the care of the city Social Assistance department since the mother has not been able to work recently. Previously, she had spent three years as a maid in a hotel and as a worker in a laundry. As leisure time activities she enjoyed sewing, reading and watching television.

Following a party one evening the car in which Mrs. Peel was riding skidded off the road and struck a telephone pole. She was admitted to the emergency department via ambulance stretcher for treatment. Questioning revealed that the patient remembered nothing about the accident, and that apparently she had been unconscious for some time.

Examination revealed:

1. Multiple facial abrasions
2. Lacerations of left lower and upper lip, left knee, right hand
3. Sanguinous oozing from nostrils
4. Contusions of ankles, left forearm, left eye, left clavicle
5. Pain on pressure over left mandible
6. Upper rim of upper denture broken
7. Pupils equal and reacting
8. B.P. 100/70, pulse 108.

X-rays of the extremities revealed no fractures or dislocations, but the radiologist reported that:

> The P.A. and lateral stereoscopic and oblique view of the mandible show a fracture through the base on the left side with minimal outward displacement of the proximal fragment and separation between the fragments amounting to a few millimeters. There is fragmentation at the fracture site with a 1 x 0.3 cm. fragment of cortical bone separated at the fracture line and lying obliquely between the distal and proximal fragments.

Demerol 75 mg. was given immediately to relieve the pain, and the facial lacerations were carefully cleansed and sutured with fine black silk. Close attention was paid to cosmetic effect. The doctor ordered 1500 units of ATS as a preventive measure against tetanus and a skin test was done. Because the results were positive the remainder of the dose was not given.

Tetanus Antitoxin

Use — Prophylactic dose of 1500 units where wounds are contaminated with soil, street dust. Treatment of tetanus — 50,000 to 100,000 units for first few days I.M. and I.V.

Sensitivity test — Carried out each time antitoxin is administered. Inject intradermally 0.1 cc. diluted 1:10 with sterile normal saline. If patient is hypersensitive to horse protein a wheal with hyperemic areola forms in 5-10 min. showing that he will react unfavorably to the antitoxin. This must be reported to the doctor. If the test is negative, give the remainder of the 1500 units I.M.

Treatment of tetanus — Saturate body with antitoxin until symptoms subside. Avoid stimuli.

Precautionary measures — Has patient a history of allergy, asthma or hay fever? Has patient ever had toxoid or antitoxin before?

Desensitization — Small initial dose, then larger doses at 20 min. intervals until desired amount has been given.

Serum reactions — Anaphylactic: give 0.5 cc. epinephrine hypodermically. Thermal: 20 min. — 1 hour after injection, chill, dyspnea, fever. Serum sickness: fever, rash, edema, joint pain — two weeks after injection.

The Preoperative Period

Upon her arrival in the ward Mrs. Peel was settled comfortably in bed. Her blood pressure, pulse, and tem-

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perature were taken, and she was observed for signs and symptoms arising from her injury. Hospital routine was explained and she was oriented to her room and equipment. A mouth care tray with a solution of one-half hydrogen peroxide and one-half normal saline was set up at the bedside and the importance of its frequent use was explained. Because it was observed that this patient was slightly disoriented at times, bed rails were applied. Close observation was made for signs of respiratory distress or shock.

Mrs. Peel was hospitalized for six days before her surgery and during this time emphasis was placed on:

1. *Relief of pain* — Demerol 75 mg. was given during her first night for severe pain and restlessness but it did not need to be repeated since aspirin and phenacetin compounds were found to be effective. Mrs. Peel's denture was repaired and the nursing staff was requested to encourage her to wear it even though it was painful, due to small lacerations on her upper gums. Nupercainal ointment applied to the denture before insertion relieved some of the discomfort, but the patient still complained of pain travelling to her left ear whenever the denture was in place.

A tensor bandage with chin padding was applied to help support the mandible. It was of some help in relieving the pain.

2. *Strict oral hygiene* — Mrs. Peel was encouraged to use mouth wash frequently. Mouth care was given at intervals throughout the day by the nursing staff. Her denture was brushed following meals and soaked in a very weak solution of mouth wash during the night. When it was explained that this routine was necessary to prevent infection of the mouth glands, fracture area, and gum lacerations, and to speed up the healing process, the patient was very cooperative in carrying out the routine as she had been instructed.

The sutured lacerations around her mouth were cleansed frequently with peroxide. They appeared to be healing well. During her second day in hospital Chloromycetin 500 mg. stat and 250 mg. q.i.d. were ordered as an added precaution against infection.

3. *Diet* — Because of the nature of her injury, Mrs. Peel was placed on a high caloric fluid diet arranged especially for her by the dietitians. She tolerated it very well although she found fluids for every meal became very tedious. The value of such a diet in preparation for surgery was explained.

4. *Explanation, reassurance and psychological support* — Consideration for her feelings, tact, understanding, and reassurance played a big role in the nursing care of this patient. In order for her to accept her condition it was necessary for the nurses to demonstrate calm acceptance of it.

As preparation for the postoperative period and the time of discharge, and in an attempt to relieve fear, anxiety and apprehension Mrs. Peel was given explanations of procedures being used and those that she could expect later on. She was told that a urinalysis and blood tests would be carried out to help the doctor gain a picture of her general health; that skin preparation done the night before surgery would help to prevent infection. The anesthetist visited her to check heart and lung action and to choose the anesthetic best suited to her and her operation. Her doctor had a talk with Mrs. Peel about her treatment and operation, and explained why surgery was necessary.

Mrs. Peel learned that her jaws would remain wired into position for 3-4 weeks, but that she would be sent home during that time. She would not be able to separate her teeth. Her diet would be fluids or very soft foods until after the wires were removed. Her mouth would feel very uncomfortable and there would be excessive oral secretions immediately postoperatively. A suction machine at the bedside would help to get rid of these. Talking would be difficult and she would be given a pencil and paper to use. If at any time she felt nauseated she was to signal for the nurse at once. It was expected that everything would go smoothly, but if an emergency should arise the wirecutters attached to the bed would be used. After the wiring, oral hygiene must be even more strictly observed. Deep breathing would help to prevent lung complications and she was instructed in the method. She was also told that she would be taken to the recovery room immediately after surgery instead of returning to her ward.

Mrs. Peel adjusted to the ward quickly and seemed to accept the idea of surgery and her postoperative treatment very well. Because of difficulty in

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talking she tended to keep to herself, but with encouragement she made friends with her roommates.

Preoperative Preparation

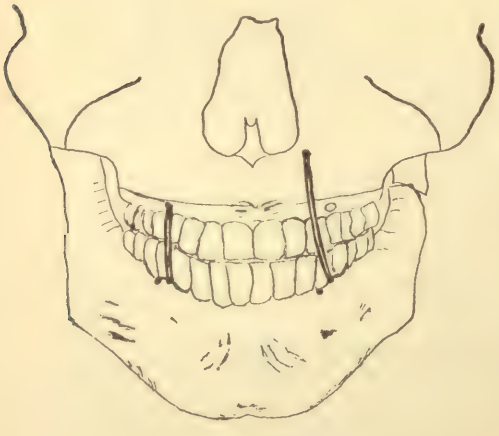
1. *Local*: The night before surgery the operative area was shaved and cleansed. The operation was scheduled for 11:00 A.M. so there was ample time during the morning to cleanse the mouth thoroughly several times and to clean the dentures and put them in a labelled container ready to go to the operating room with the patient. It was essential that the mouth be as clean as possible to lessen the danger of lung complications and mouth infection after surgery.

2. *Physical*: Mrs. Peel received an enema the night before surgery, and a complete bath in the morning. She was encouraged to be up walking before her preoperative hypodermic injection and told that she must remain in bed following it. Her urinalysis report showed 2-4 white blood cells, and her hemoglobin was 81 per cent or 12.0 grams.

The Anesthetic

The anesthetist ordered Seconal gr. 1½ at bedtime to give the patient a good night's sleep, and Demerol 75 mg. with scopolamine gr. 1/150 one hour preoperatively to make her drowsy and less apprehensive, to lessen secretions and to make the anesthetic induction easier.

In the operating room, 500 cc. of 5% glucose in normal saline was established and sodium Pentothal was added to induce anesthesia. General anesthetics such as Pentothal act on the brain to produce complete loss of consciousness. After the patient loses consciousness and the concentration of the drug in the body is increased, the voluntary muscles relax and the patient passes into the stage of surgical anesthesia. Sometimes other drugs, such as Flaxedil, are given. They act on the motor nerve endings to produce temporary paralysis that gives muscular relaxation without having to deepen the stage of anesthesia. Oxygen was given, and a catheter was introduced into the nares. Nitrous oxide, a gas, was used to depress the cerebral cortex and sustain the period of anesthesia. Demerol 100 mg. was given in divided doses during the period of anesthesia.



Intradental Wiring

The Operation

At operation it was found that there was a left subcondylar fracture of the mandible with displacement of the body posteriorly. The upper jaw was edentulous, and there was some splintering along the inferior border of the maxilla which accounted for the pain when the denture was in place.

A No. 24 gauge soft brass wire which was flexible but had tensile strength was used to form an eyelet, and attached to the left bicuspid region in the lower jaw and secured there. An incision was made in the left gingival labial sulcus and deepened to the pyriform fossa where the periosteum was incised and reflected. A drill hole was made through the fossa and a loop of wire was inserted and secured to the eyelet on the lower jaw. The upper denture was inserted and attached through a hook inserted into it at the time of repair to an eyelet attached to the right lower bicuspids. The jaw was securely immobilized, the dentures were firmly anchored, and there was good occlusion of the teeth.

The comminuted fragment was left in place because it still appeared to be attached to the soft tissues and therefore would retain its vitality and aid in restoring bone continuity.

An x-ray the day after surgery revealed that:

> Intradental wiring is noted holding the jaws together. The fracture of the base of the neck of the condyle is noted with outward swinging of the free end.

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(fretfulness, drooling, constipation, etc.)

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Postoperative Care

Immediately following surgery Mrs. Peel was taken on her own bed to the recovery room. Wire cutters had been previously taped to the bed ready for immediate use should the need arise. She was conscious; her blood pressure, pulse and respirations were checked at 15-minute intervals, and she was watched carefully for signs of shock or nausea. Suction equipment was ready for use if the patient showed signs of respiratory distress due to nausea or excess secretions. Mrs. Peel remained in the recovery room for two hours during which her blood pressure rose slightly. There was no oozing apparent, and no respiratory difficulties.

The doctor left the following orders:

1. Demerol 50 mg. q.4 h., p.r.n. for 24 hours.
2. Cut anchoring wire on left, if jaws need emergency opening.
3. Same diet as preoperatively.

When Mrs. Peel returned to her ward she was very drowsy. Her blood pressure, pulse, respirations and color were noted and charted. There was no sanguinous oozing from her mouth, but excess salivation was present. She was not in pain. A suction machine was kept at the bedside as well as a mouth care tray. The complete ward staff was alerted to the fact that this patient was to be given nothing to drink until 9:00 P.M., and after that, only by her own nurse for the remainder of the evening. They were asked to report immediately any signs of nausea or distress. It was thought advisable to move her nearer to the chart room so that she could be watched more carefully. Her bell cord was pinned within easy reach. She was suctioned frequently for small amounts of mucus.

Special Nursing Responsibilities

1. *Provide a free airway*: Careful observation was necessary because aspiration of vomitus or saliva would endanger the patient's life or result in atelectasis or pneumonia. The wire-cutters were never taken from the bedside, and fortunately they were never needed. It was a responsibility of the nurses on each shift to know how to operate the suction and to check that it was in working order. An ounce or two of dettol solution put into the bottle after emptying and washing it made cleaning easier the next time. The amount and character of the drainage was charted.

Mrs. Peel found it easier to breathe and to get rid of secretions if the head of the bed was raised. She always had a box of celluwipes, and her discard bag was changed several times daily. A face towel was used to cover her pillow and absorb secretions that drained from her mouth during the night.

2. *Control of infection*: Strict oral hygiene was necessary to offset the effects of stagnation of secretions and a fetid breath caused by lack of normal mouth function. A child-sized tooth brush was obtained and her mouth received a thorough cleansing in the morning, following all meals, and at night. In addition applicators and hydrogen peroxide solution were used and cold cream was applied to her dry, cracked lips. By these measures post-operative parotitis, infection of the fracture area, and infection of the gums and around the wires was avoided. It also served to keep her mouth fresh and pleasant-tasting.

3. *Communication*: The position of the teeth due to the wiring, along with swelling and excess saliva made coherent speech almost impossible. A pencil and paper were used by the patient in answering questions and making requests. Frequent visits by the nurse and anticipation of the patient's needs made it much easier for Mrs. Peel to cope with the situation. Whenever possible, questions to her were phrased in such a way that "yes" or "no" was the only answer required and a nod was sufficient. Mrs. Peel seemed to enjoy the company of the staff and patients, but was very self-conscious about her condition.

4. *Relief of Pain*: The wise use of narcotics during the first 24 hours after surgery carried Mrs. Peel over the period of severe pain. The use of ice caps was found effective in overcoming some of the later discomfort. Sedation at night along with good nursing measures to make her comfortable ensured a good sleep. A crushed tablet of Aspirin and phenacetin compound with codeine gr. ½ gave relief from the occasional headaches that she

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suffered due to the constant pressure exerted on her jaws.

5. *Nutrition*: A record of intake and output and of the type of fluid taken helped us ascertain the amount of nourishment that Mrs. Peel received. Her diet proved to be quite a problem. She became discouraged, and her morale was low because of the monotony of her meals. She preferred a straw for drinking, but spoons, feeding cups and asepto syringes have been found useful.

With these patients there is often interference with carbohydrate digestion due to the reduction in ptyalin action. As a result the carbohydrate content of the diet is made lower than normal. Variety is essential. Fluids should be appetizing, properly seasoned, appeal to the eye, and be served at the proper temperature. Garnishes should be used whenever possible. Frequent small feedings were tolerated better than three meals daily as Mrs. Peel complained that she felt bloated if she attempted to take the full amount of fluid on her meal tray at one time.

The dietitians and the nurses stressed the importance of her diet and suggested ways to give variety. The dietitian made up a special milkshake and eggnog recipe for Mrs. Peel to use at home which took into consideration her nutritional requirements.

High Calorie Milkshake

Total volume 70 oz.

P.146 F.123 CHO.322		Cal. 2940
whole milk	40 oz. (5 cups)	1200 cc.
glucose	6 tablespoons	60 gm.
egg	6 medium	300 gm.
casilan	1 cup	60 gm.
salt		
ice cream	8 scoops	500 gm.
choc. syrup	6 oz. (⅔ cup)	

High Calorie Eggnog

Total volume 1 pint

milk	14 oz. (1⅔ cups)
eggs	3
glucose	2 tbsp.
skim milk powder	3 tbsp.
vanilla	
salt	

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cereals — as gruels thinned with milk or cream and strained; soups — any type, strained; vegetables — well cooked, pureed or creamed to thin; meats — finely ground or scraped, then sieved — may be added to soup; desserts, ice cream, jello, sherbet, custard, thin puddings; beverages — cocoa, milk, eggnog, milkshakes, juices. Strained baby foods are often found convenient to use.

This diet is expensive for the patient on a low budget. The Social Assistance department was able to give Mrs. Peel extra help. She was encouraged to weigh herself daily at home, and to try to maintain her normal weight.

6. *Emotional Support*: Mrs. Peel required much reassurance and psychological support. She had to have the fact demonstrated to her that she was socially acceptable. The nurses were careful to have the right attitude toward her treatments. Even though she seemed to accept things very well preoperatively, when actually faced with the situation Mrs. Peel tended towards depression. The nurses were faced with the problem of diverting her attention. Books and magazines helped to some extent. Praise for the way she handled her own treatments and feedings also raised her spirits. She was encouraged to become independent, and to take an interest in her treatments. Helping her to arrange her hair before visiting hours was one way for us to demonstrate our interest in her as an individual. When the sutures were removed from the lacerated areas there were only thin hairline scars. This helped to cheer her.

Three days after surgery Mrs. Peel was discharged. The wires were removed three weeks later. Her jaw was stiff for a while, but gradually exercise brought it back to normal. Her upper denture required adjusting so that it fitted snugly.

Book Reviews

Psychology, the Nurse and the Patient by Doris M. Odlum, M.A., B.A., M.R.C.S., L.R.C.P., D.P.M., 200 pages. British Book Service (Canada) Ltd., 1068 Broadview Avenue, Toronto 6. 1959. Price $2.70. *Reviewed by Mrs. E. Gibson, Nursing Counsellor, Mental Health Services, Essondale, B.C.*

There is so much diverse material crowded into the pages of this text that while the ground may be covered, it is too thinly spread to be of much use to a professional person. The material is over-simplified, superficial and sometimes open to question. For example, in Chapter Three on "Inborn Mental Factors," the author quotes extensively from William McDougall, many of whose theories are not currently accepted. The organization of material is rambling.

Much of the material refers specifically to English hospitals, their customs and community organization, and would not apply in Canada except as a matter of interest.

The last 60 pages on mental illness and the psychoneuroses are reasonably up-to-date in approach, but they deal with a subject too vast and complex to be included in a book of this type.



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VISITING NEW ZEALAND

THE TWELFTH CONGRESS of the ICN, to be held in Melbourne next year, will provide many nurses with a unique opportunity to tour this area. New Zealand is only four hours' flying time from Australia. It has so many attractions that it is impossible to list them all. A tour of the country, however, will soon reveal why it is known as "a holiday world in itself."

Four alternative tours are suggested. Two of these tours precede and two follow the congress. Although one tour described here covers both North and South Islands, it is possible for tourists to arrange itineraries to take in one island only.

A comprehensive tour begins in Auckland. With a population of 422,900, Auckland is New Zealand's largest city. It is the main port of call for ocean liners and for world air services. It is a beautiful city, situated on an isthmus overlooking two fine harbors — to the east the Waitemata and to the west the Manukau. Though tourists could spend days just in and around the city visiting the many fine features that have given it the title of the "Queen City," this tour allows only one day. This permits visitors to form an impression of the extensive and beautiful parks, gardens and reserves; the magnificent civic buildings; the spacious beaches. They will gaze from the lookout on Mount Eden across the extensive waters of the Waitemata harbor, dominated by a graceful bridge linking the city with the residential North Shore area.

On the second day visitors leave the bustling city behind and pass through the lush green pastures of the Waikato to Waitomo and its world-famous glow-worm caves. This spectacle is one of the wonders of the world. The modern tourist hotel at Waitomo is only 400 yards from the caves. Guided tours are available daily. The scene in the caves, viewed from a boat, is of indescribable beauty. From a canopy of darkness overhead, the soft illumination of a million tiny lights is reflected as dim radiance by the still waters.

On the third day the tour moves from the fertile grasslands of the Waikato to the volcanic plateau in the center of the North Island. Here the party will spend two full days in and around a thermal wonderland. Rotorua is as unique as it is beautiful. Experienced world travellers maintain that it is the most spectacular thermal region in the world. Perhaps the most impressive attraction of all is the enchanting music and dancing of the Maori people. Concerts are held severay evenings a week for most of the year. In the model Pa (a Maori village) the visitor sees the novel uses to which the Maori put thermal steam. There are many examples of the intricate and impressive wood carvings which symbolize the ancient traditional figures of Maori folklore.

At Wairakei, 55 miles from Rotorua, there are two attractions which, although similar in origin, are diverse in appeal. The first of these, Geyser Valley, is an area of thermal activity that rivals Rotorua. The second, the generation of electricity from subterranean steam is an unusual experiment. Wairakei is the only place in the world where "wet" geothermal steam is used in this way.

A day in Christchurch will show visitors why the city has been called "the most English city outside England." It was planned and built around its Anglican Cathedral. Everywhere, the English influence is predominant. The Avon River, its grassy banks planted with flower beds and stately trees, winds through the heart of the city.

From Christchurch the tour moves across the Canterbury plains to the rugged southern Alps. This lofty range, towering in places to 12,000 feet, stretches the length of the South Island. From many high snowfields come the swift-flowing waters that feed numerous powerhouses or fill the placid waters of the beautiful southern lakes. The rivers are stocked with salmon and trout — fighting fish for which this area is renowned.

An alpine hotel, the Hermitage, is set in a beautiful valley with an excellent view of Mount Cook (12,349 feet). From this comfortable modern hotel, visitors can undertake all types of excursions. They can enjoy leisurely walks among virgin mountain forests or mountaineering expeditions up the varied rugged, difficult peaks. Within easy reach of the Hermitage, glacier and mountain scenery are at their best. One of the more unusual attractions of the Mount Cook area is the thrill of a scenic flight around the towering peaks in a ski-equipped aircraft that lands on snowy airstrips.

This description of the beauties of nature that the visitor to New Zealand can enjoy was prepared by the New Zealand Government Tourist and Publicity Department.

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On the ninth day the tour takes the tourist through the heart of the South Island. Queenstown is one of the most fascinating areas for holiday-makers. It lies on the eastern shore of Lake Wakatipu, which curves like the letter "S" through impressive mountain country. Frequent launch trips on the lake give the visitor an opportunity to see the scenery from the best viewpoints. Across the lake and rising 7,600 feet is the "Remarkable," a sierra-type range of mountains named for the startling color changes that occur as the sun touches the different peaks.

On the 11th day the tour moves to Milford Sound. For the first part of this journey the route skirts Lake Te Anau, then it runs into rugged mountain country and through the Homer Tunnel. Until this tunnel was opened the only land access to this area was by walking over the Milford Track.

Of all the famous sights of New Zealand, Milford is the one that most people regard as the finest. Everything that man has put here, and anything that man is likely to put here, is completely dwarfed by the splendor of mountains, rising almost vertically from the waters of the fiord. The modern hotel at Milford is dwarfed beneath the towering Sheerdown Range. From a cleft in a 500-foot precipice nearby the Bowen Falls plunges to a hidden pool far below.

With three days left the party leaves Milford on the 13th day and travels along the Cleddau and Eglinton Valleys back through the Homer Tunnel to Dunedin. Dunedin is the second largest city in the South Island. It is often called "The Edinburgh of the South" from its origin as a Scots settlement and its notable academic institutions. Spread over seven hills at the head of the Otago Harbor, Dunedin has all the features of a scenic city as well as those of learning. Its university and medical school have become hallmarks of professional achievement in the southern hemisphere.

The last land journey on this tour is from Dunedin to Christchurch along the eastern coastline of the South Island and through the Canterbury Plains. This is the grazing ground for New Zealand's famed export meat, prime Canterbury lamb.

TEAL air services linking Australia and New Zealand depart regularly from the airport at Harewood, Christchurch. As the airliner wings over the majestic peaks of the southern Alps, tourists will have a last look at the "backbone" of New Zealand as they cross the Tasman Sea to the shores of Australia where the congress awaits them.



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ALBERTA

Matron for active 50-bed hospital in town of 3,500 population, 128 miles southeast of Edmonton on the main C.N.R. line. State qualifications & experience; also salary expected. Blue Cross, M.S.I. & pension plan available. Applications should be sent to: Secretary-Treasurer, Municipal Hospital, Wainright, Alberta.

Registered Nurses & Certified Nursing Assistants (Immediately for General Duty) in active 65-bed hospital in Peace River area. 40-hr. wk., liberal personnel policies. Credit for past experience. Train fare from any point in Canada refunded after 1-yr. employment. Please apply: Sister Superior, Providence Hospital, High Prairie, Alberta.

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Registered General Duty Nurse Salary $270 - $285 per mo., 1 mo. vacation with pay after 1-year service. Apply: Matron, Municipal Hospital, Raymond, Alberta.

Registered Nurses for Fairview Municipal Hospital. Wages $300-$330, $10 extra for 11-7 shift. Apply: Mrs. P. Landry, Matron, Municipal Hospital, Fairview, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

Graduate Nurses (4) for Maternity, Pediatrics, Medicine & Surgery. Wages $285 - $300 according to experience. Contact- Les Soeurs de la Charité de N.D. d'Evron Hôpital St. Louis, Bonnyville, Alberta.

BRITISH COLUMBIA

Director of Nursing for 110-bed hospital in Northwestern B.C. Salary open. Excellent personnel policies. Apply stating qualifications & experience to: Administrator, General Hospital, Prince Rupert, British Columbia.

Nursing Supervisor B.C. Registered for new hospital at Golden, British Columbia, picturesque village in the beautiful Canadian Rockies, on C.P.R. & Trans-Canada Highway, 170-miles west of Calgary, Alberta. Please indicate qualifications & salary expected. Full information regarding duties & hospital operation & organization available on request. **Graduate Nurses- B.C. Registered Nurses** starting $285 per mo., Graduate Nurses $270 per mo., 28-days annual vacation, 10 statutory holidays per year, accommodation available in new modern nurses' residence on hospital grounds. Apply to: C. F. Collins, Administrator, Golden & District General Hospital, P.O. Box 230, Golden, British Columbia.

Supervisor (Evening & Night Service) for 110-bed hospital in Northwestern B.C. Salary $357 - $428. Residence available. Apply stating qualifications & experience to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Registered Nurses (3) for Queen Charlotte Islands General Hospital. Assistance in travelling expenses & salary approved by provincial nurses' association is offered. This is an opportunity for service in a home mission hospital operated by the United Church of Canada. Apply to: Hospital Administrator, Queen Charlotte City, British Columbia.

General Duty Nurses for small active hospital. Salary $290 with 2 yearly increments. Room & board $35. For further particulars write: Matron, General Hospital, Fort Nelson, British Columbia.

General Duty Nurses for 110-bed hospital in Northwestern B.C. Salary range $312 - $374 B.C. Reg. Nurses; others $297. Residence available. For particulars apply to: Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

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General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospitals. Personnel policy in accordance with R.N.A.B.C. Rooms available in nurses' residence. Nurses Aides (with vcational training). Salary: $177 - $201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses Salary $297 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital, Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $285 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 year. Apply: Director of Nursing, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses $285**, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Graduate Nurses (4) immediately for 40-bed hospital. Salary $300 per mo. for B.C. Registered Nurses & $15 less per mo. for non-registered nurses. 3 yearly increments, 40-hr. wk., 1½-days sick leave with pay per mo., 28-days vacation with pay after 1-year of employment & 10 legal days per year. Fare from anywhere in Canada advanced & need not be repaid if you stay 6-months. Superannuation benefits, uniforms are laundered gratis by the hospital. There is a new modern residence which is available for $45 to $50 per month. Interesting social advantages as an excellent Choral Group, excellent educational opportunities and good sporting, Skating, Bowling, Fishing, Boating, Curling, Hunting, etc. Kindly apply giving references to: Sister Superior, St. John Hospital, Vanderhoof, British Columbia.

Operating Room Nurses with postgraduate training & **General Duty Nurses** for 450-bed hospital. B.C. registration required. Salaries & personnel policies in accordance with R.N.A.B.C. Apply: Director of Nursing Service, St. Joseph's Hospital, Victoria, British Columbia.

MANITOBA

Science Instructor for school of nursing, 150-bed General Hospital. **Registered Nurse** with postgraduate education preferred for courses in Anatomy-Physiology, combined Microbiology-Bacteriology, and Pharmacology. Duties to commence immediately. Apply in writing to: Personnel Officer, General Hospital, Brandon, Manitoba.

Registered Nurse (1-immediately) for 11-bed hospital. Salary $310 per mo., gross with 8 - $5.00 increments over a period of 4-yr. service, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit. Birch River Manitoba.

Graduate Nurses (2), Licensed Practical Nurse (1) for 22-bed hospital. Salary $315 and $215 per mo. resp. with $5.00 increments after 6-mo. service. Board & room $45 per mo., 4-wk. vacation plus statutory holidays. Apply to: Matron. District Hospital, Vita, Manitoba.

Registered Nurses (2) Position of Matron will become vacated approx. April 15th. 1961, at the Glenboro Medical Nursing Unit 16B. Applications from R.N.'s with a view of being appointed Matron will be welcomed. Starting salary for R.N.'s $295 per mo., liberal sick leave & vacation benefits. 40-hr. wk. Glenboro is located 100-mi. west of Winnipeg, & 50-mi. east of Brandon on No. 2 Highway. Hospital is approx. 5-yrs. old, & nurses' residence was built in 1959. Apply to: Mr. S. A. Oleson, Box # 310, Glenboro, Manitoba.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

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(5) Hospital Staff Nurses —$3,300 to $3,750 per annum

(6) Certified Nursing Assistants, Licensed Practical Nurses and Nurses' Aides: up to $2,400 per annum depending upon qualifications and location of positions.

- Room, board and laundry in residence at reasonable rates. Statutory holidays. Three weeks annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.
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For interesting, challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 705 Commercial Building, 169 Pioneer Avenue, Winnipeg 1, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

(or) Chief, Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurse for General Duty. Starting salary $290 per mo., 6 increments of $5.00 at 6-mo. intervals. Board & room $45 per mo. For further information, phone: Boissevain 61.

General Duty Nurses for Clearwater Lake Hospital, The Pas, Manitoba. Interesting nursing with White, Indian & Eskimo patients both in general & tuberculosis wards. Starting salary $300 per mo. Good accommodation in nurses' residence. 3-wk. vacation, 40-hr. wk., 10 statutory holidays, group insurance plan. Apply: Director of Nursing Services, Sanatorium Board of Manitoba, 1654 Portage Avenue, Winnipeg, Manitoba.

NOVA SCOTIA

Registered Laboratory Technician. Good personnel policies. Apply stating experience & qualifications, to: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

Operating Room Nurse — 40-hr. wk., good starting salary. Apply to: Director of Nurses, Western Kings Memorial Hospital, Berwick, Nova Scotia.

ONTARIO

Director of Nursing for 50-bed hospital in beauty spot of lakes & rivers, cooperative & pleasant staff. 5-day wk., pension plan, salary commensurate with experience. Apply: Administrator, Huntsville District Memorial Hospital, Huntsville, Ontario.

Director of Nursing for 80-bed General Hospital, 20-mi. from London. New Hospital to be built early in 1961. Excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, or phone collect. Strathroy, Ontario.

Director of Nursing Service for 34-bed hospital (planning an extension). Salary commensurate with preparation & experience. Apply: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario.

Director — Training School for Well Baby Nurses. Salary dependent upon qualifications. Also opening for **Night Supervisor.** For further information write to: Executive Director, Canadian Mothercraft Society, 341 Bloor Street West, Toronto 5, Ontario.

Assistant Superintendent, Registered Nurse for 75-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England.

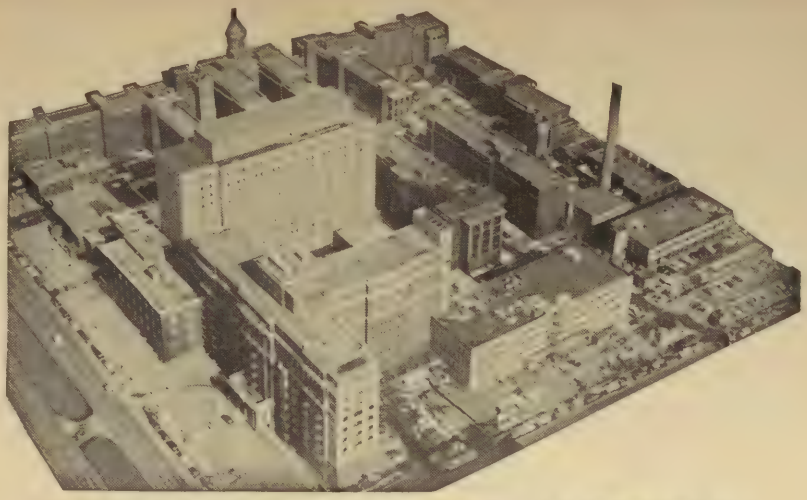
Registered Nurses Applications & enquiries are invited for General Duty positions on the staff of modern, well-equipped 33-bed hospital in new mining town, about 250-mi. East of Port Arthur & North-West of White River, Ontario. Excellent salary & fringe benefits, liberal policies regarding accommodation & vacation. Population 2,500. Nurses' residence comprises individual self-contained apartments. Apply, stating qualifications, experience, age, marital status, phone No. etc., to: The Administrator, General Hospital, Manitouwadge, Ontario. Phone TAylor 6-3251.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

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Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $300 & $210 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. Hospital of Ontario pension plan. Residence accommodation available. Assistance with transportation can be arranged. Apply: Director of Nurses, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for all departments in a new hospital, opening in December. Good personnel policies, O.H.A. Pension Plan. Apply: Director of Nursing, Ross Memorial Hospital, Lindsay, Ontario.



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Qualifications —post-basic nursing education desirable.

Experience —at least five years nursing experience, including supervisory and/or administrative — some knowledge of community health and welfare organizations, — business experience desirable.

Salary range —from $400 to $486 per mo.; other benefits in accord with RNABC personnel policies.

Applications or enquiries may be addressed to:

EXECUTIVE SECRETARY, REGISTERED NURSES' ASSOCIATION OF B.C.
2524 CYPRESS ST., VANCOUVER 9, B.C.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Deduction for room & board $30. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses & Certified Nursing Assistants for 26-bed hospital. R.N. salary $290-$335. 28-day vacation after 1-yr. C.N.A. salary $210-$240, 2-wk. vacation after 1-yr., 3-wk. after 2-yr. Credit for past experience, $5.00 increment every 6-mo., 40-hr. wk., 8 statutory holidays. Room & board residence $28.50 per mo., 1-day sick leave per mo. Apply to: Mrs. G. Gordon, Superintendent, District Memorial Hospital, Box 37, Nipigon, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses for General Duty in all departments including premature & new-born nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty. Initial gross salary $270, 40-hr. wk., modern nurses' residence, good personnel policies, pension plan. Apply: Superintendent, Louise Marshall Hospital, Mount Forest, Ontario.

Registered Nurses for General Duty in modern 18-bed Private Hospital, in iron mining town, 150-mi. north of Sault Ste. Marie, Ontario. Starting salary $281 min. to $316 max. for experience, less $20 per mo. for maintenance. Excellent accommodations & personnel policies, transportation allowance after 6-mo. service. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered General Duty Nurses for 34-bed General Hospital. Good salary & personnel policies, 40-hr. wk. Adjacent attractive residence, recreation facilities. For further particulars, apply: Miss A. Burnett, Superintendent, Niagara Hospital, Niagara-on-the-Lake, Ontario.

Registered General Duty Nurses for 76-bed General Hospital in small town, 16-mi. from Sarnia. Good personnel policies in effect. Limited residence accommodation available. Apply to: Administrator, Charlotte Eleanor Englehart Hospital, Petrolia, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 75-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305, for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses & Certified Nursing Assistants for modern 50-bed active hospital, 40-hr. wk. with all statutory holidays, pension plan & sick leave benefits. Meaford is situated on Georgian Bay & is an all year resort town. For further information apply to: Director of Nursing Services, General Hospital, Meaford, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurse Starting salary $270 per mo. **Charge Nurse** salary $300 per mo. for 50-bed hospital, resort area. 5-day wk. Apply: Administratrix, Huntsville District Memorial Hospital, Huntsville,, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $270 monthly, Graduates at $250; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A. Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing, Leamington District Memorial Hospital, Leamington, Ontario.

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The salary range for each of these posts is US $6,000 - $8,000 per annum (net of tax), plus allowances.

3) TAIWAN University School of Nursing: basic and post-basic programs.
The salary range for this post is US $7,300 - $9,500 per annum, (net of tax), plus allowances.

Initial contracts are for two years. Travel to and from duty stations is paid by the Organization. Paid home leave may be taken at 2-year intervals, subject to renewal of contract.

Applications may be made to:

PERSONNEL OFFICE, WORLD HEALTH ORGANIZATION,
PALAIS DES NATIONS, GENEVA, SWITZERLAND



THE WINNIPEG GENERAL HOSPITAL

is Recruiting General Duty Nurses for all Services

SEND APPLICATIONS DIRECTLY TO:

THE PERSONNEL DIRECTOR, WINNIPEG GENERAL HOSPITAL
WINNIPEG 3, MANITOBA

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $285 per mo. with recognition for P.G. courses. 40-hr. wk. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses. District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. 40-hr. wk., 8 statutory holidays, full particulars, apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Duty Staff Nurses for 80-bed hospital, 20-mi. from London. Accommodation available in residence, excellent personnel policies. Apply to: Administrator, Strathroy General Hospital, Strathroy, Ontario.

General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time allowance. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Public Health Nurse (Immediately) for home visiting in a child health research project in London. Car required, starting salary $3,200 plus mileage allowance. Apply to: Dr. Carol Buck, U.W.O. Medical School, 346 South Street, London, Ontario.

Nurses (2) for United Church Mission Hospital in northern British Columbia. Salary $285 per mo. An opportunity for Christian service. Apply: Wrinch Memorial Hospital, **Hazelton, British Columbia. or** Dr. M. C. Macdonald, Board of Home Missions, United Church, 85 St. Clair Avenue East, **Toronto, Ontario.**

P.E.I.

Director of Nursing Education, degree preferred, **Medical-Surgical Clinical Instructor, Nursing Arts Instructor,** for school associated with 200-bed hospital, salary based on qualifications & experience. Apply to: Director of Nursing, Prince Edward Island Hospital, Charlottetown, Prince Edward Island.

BERMUDA

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write: Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Clinical Instructor in Rehabilitation Nursing and Rehabilitation Nurse for expanding program in a New England rehabilitation facility. Full details upon request. Write Box N, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $275 per mo. 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurses for Obstetrical Service. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.



Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

. . . THEY WORK AT

COOK COUNTY HOSPITAL

. . . in one of the Largest Most Stimulating Medical Centers in the World

Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at *$345-$385* for a *37½ hour week*. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

OPERATING ROOM NURSES

For expanding 374 bed General Hospital located on Long Island Sound just 45 minutes from New York City.

- Starting salary $355, annual increases for four years.
- $15 bonus paid for each night on call.
- Paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.
- Scholarship paid available for continued collegiate study.

Apply: Operating Room Supervisor

NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

Operating Room Nurses for modern well-equipped department in 140-bed General Hospital, no rotation, but required to take night calls. Good personnel policies & salary in accordance with ANPQ recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

SASKATCHEWAN

Operating Room Supervisor with postgraduate training, for 180-bed hospital. Average monthly surgical load - 157. Basic Salary $335 per mo. Duties consist of administration of department & educational program of students in department. Apply stating qualifications & experience to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Obstetrical Supervisor for 225-bed General Hospital, good personnel policies. For further information contact: Director of Nursing, Union Hospital, Moose Jaw, Saskatchewan.

Registered Nurses (2) for 19-bed hospital at Vanguard, Sask. Salary range $280 - $355. One year's experience $295 - $355. 3-wk. vacation, sick leave, residence on grounds with T.V. Apply to: The Secretary, Vanguard Union Hospital, Vanguard, Saskatchewan.

Registered Nurses for General Duty in Medical & Surgical Wards. Salary $270-$345, good personnel policies & liberal holiday allowance. Apply: Director of Nursing, Providence Hospital, Moose Jaw, Saskatchewan.

Registered Nurses for General Duty for 24-bed hospital, a new 34-bed hospital presently under construction. Present hospital to be converted to a nursing home for the aged. Salary schedule $290-$350 gross, $10 increments every 6-mo. Living accommodation available in new residence. T.V. set, board & lodging $34.50 per mo., 3-wk. vacation after 1 year service. 8 statutory holidays, 1½ days sick leave accumulative up to 90-days, 40-hr. wk., bus service daily to major city. Apply to: Secretary-Manager, Union Hospital, Leader, Saskatchewan.

Registered General Duty Nurses (2) for modern 7-bed company hospital. Salary $315 per mo., $10 accredited postgraduate courses, overtime paid, $25 increment after 1 year. Full maintenance, transportation paid from point of hire in exchange for 1 year service. Group insurance & attractive vacation benefits. Excellent recreational facilities, boating, fishing, swimming, bowling, etc. Apply: Miss N. Prefontaine, R.N., Matron, Gunnar Mines Hospital, Uranium City, Saskatchewan.

U.S.A.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses (Come to sunny California) **Staff & Supervisory permanent positions,** various departments, days, eves, nights. Excellent starting salary, increments, benefits & working conditions in one of the largest & finest general hospitals in the West. For details write: Personnel Department, Queen of Angels Hospital, 2301 Bellevue Avenue, Los Angeles 26, California.

Registered Nurses excellent opportunities. Progressive 440-bed General Hospital, expanding to 525-beds in early 1961. Expansion is creating openings in all areas. Salary range $370 - $400 per mo., $25 P.M. & night differential. $25 additional for surgery. Liberal vacation plan, 7 paid holidays, 40 hr. wk. health insurance & retirement plan. Close to all summer & winter, mountain & ocean activities. Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for private 258-bed hospital for men, women & children. Staff Nurse salaries from $335 - $395, differentials for evenings, nights, communicable disease, operating room & delivery. Opportunities in all clinical areas. Holidays, vacations, sick leave & health insurance. California registration required. Applications & details furnished on request. Contact: Personnel Director, Children's Hospital, 3700 California Street, San Francisco 18, California.

Registered Nurses for General Duty in modern, accredited 76-bed hospital — South Central California near Sequoia National Park. Good salary & benefits. Excellent working conditions. Ideal community. Winter & Summer recreation Transportation to hospital paid on suitable confirmation of employment. Must qualify for registration in California. For details write: Administrator, Memorial Hospital at Exeter, 215 Crespi Avenue, Exeter, California.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available.

Good personnel policies in effect including medical welfare plan, 40 hour week — four weeks vacation.

Salary $285 - $342 per month
with consideration for experience or special preparation.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

SUNNYBROOK HOSPITAL, TORONTO
DEER LODGE HOSPITAL, WINNIPEG
QUEEN MARY VETERANS' HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
LANCASTER HOSPITAL, SAINT JOHN, N.B.
STE. ANNE DE BELLEVUE VETERANS HOSPITAL, P.Q.
SHAUGHNESSY HOSPITAL, VANCOUVER, B.C.

Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence—for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto.
MANITOBA — 266 Graham Ave., Winnipeg.
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal
BRITISH COLUMBIA — 1110 Georgia St. West, Vancouver, B.C.

GENERAL DUTY NURSES

required by

The Dauphin General Hospital Ultra-modern 100 bed hospital in process of construction located in the beautiful Riding Mountain Resort area of Manitoba. 40 hour week, excellent personnel policies. Residence facilities, minimum starting salary $280 per month, assistance with transportation given if necessary.

Apply to: Superintendent of Nurses
DAUPHIN GENERAL HOSPITAL
DAUPHIN, MANITOBA

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

General Duty Nurses — J.C.A.H. accredited 99-bed hospital midway between Los Angeles & San Francisco. Salary depends upon experience & qualifications. Rooms available in modern nurses' residence $10 per mo., 40-hr. wk., 15 days vacation, liberal sick leave, 12 holidays. Social Security benefits. Write: Superintendent of Nurses, General Hospital, Tulare, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses — San Joaquin General Hospital, a teaching hospital with internes, residents, & school of professional nursing. Positions available on most services on all shifts. Starting salary $376 per mo., differential for evening & nights. Laundry uniforms $5.00 per mo., liberal personnel policies, living facilities for single persons on hospital grounds. Contact: Personnel Director, 732 East Main Street, Stockton, California.

General Duty Nurses for 72-bed hospital located in college town in mountainous portion of Colorado. Salary $330 per mo. with periodic increases, fringe benefits — including meals, sick leave, vacation, etc. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Good salary, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Staff Nurses & Licensed Practical Nurses (Openings in several areas, all shifts.) 37½-hr. work wk., in small community hospital, 2-mi. from Boston. Living quarters available. Minimum starting pay $70 R.N.'s., L.P.N's. $58 per wk. Experience considered, differentials for reliefs, nights. Contact: Director of Nurses, Chelsea Memorial Hospital, Chelsea, Massachusetts.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Graduate Nurse for 59-bed accredited community hospital, 35-mi. from either Philadelphia or Atlantic City. Salary $300 plus. Full time, 3 to 11 shift, good personnel policies. Write: Administrator, Community Hospital, Elmer, New Jersey.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $270-$320 per mo. Certified Nursing Assistants $200-$220 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

REGISTERED NURSES

FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $270 - $310 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

GENERAL DUTY STAFF

HEAD NURSE FOR NEW PSYCHIATRIC UNIT TO BE OPENED IN FROM FOUR TO SIX MONTHS.

For further information write:

THE DIRECTOR OF NURSING
PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses (All Clinical Services) Base salary $319, differential for 3-11 and 11-7 shifts, liberal personnel policies include sick leave retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs — housing available on campus or in vicinity of hospitals. Apply: Director of Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Supervisors — Medical-Surgical, Pediatrics, Obstetrics & Psychiatric. Base salary $400 to $439, depending upon preparation & experience. Liberal personnel policies include sick leave, retirement plan, 3-wks. vacation & laundry of uniforms. Orientation & in-service programs. Housing available on campus or in vicinity of hospitals. Apply: Director Nursing Service, The University of Texas-Medical Branch Hospitals, Galveston, Texas.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of Oregon medical school. Salary starts at $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland I, Oregon.

Staff Nurses: Are you interested in working in a fully accredited 71-bed hospital with high standards of patient care? For complete information write to: Director of Nursing, Gifford Memorial Hospital, Randolph, Vermont.

General Duty Nurses for fully approved 390-bed County Hospital, affiliated with University schools of Medicine & Nursing. Starting salary $345, 40-hr. wk., liberal shift differential & other policies. For information write: Director Nursing Service, King County Hospital, Seattle 4, Washington.

Operating Room Supervisor for 238-bed JCAH approved hospital. Intern, Resident & Nursing Education programs. Candidates with BS degree preferred. Apply to: Mrs. Virginia Krahl, Director of Nursing Service, Cottage Hospital, 320 West Pueblo Street, Santa Barbara, California.

BRITISH COLUMBIA

Operating Room Supervisor for modern 125-bed Regional Hospital. Includes C.S.R. & Emergency. Basic 1961 salary $342 plus increments for experience & qualifications. Experience & initiative needed. Apply: Director of Nursing, Regional Hospital, Prince George, British Columbia.

MANITOBA

Registered Nurses for active 28-bed hospital. Daily bus to & from Brandon; 6-mi. to main line of C.N.R. Basic salary $290 with increments to $330, past experience recognized, 5-day wk., 10 statutory holidays, 3-wk. vacation after first year. Residence accommodation available, board & room $50 per mo., uniforms laundered free. Apply immediately to: Miss M. G. Dunn, Hamiota District Hospital, Hamiota, Manitoba.

Registered & Licensed Practical Nurses. Salary rating for Registered Nurses, min. $281 - max. $319 per mo. with $10 additional for evening duty; for Licensed Practical Nurses min. $218 - max. $242 per mo. 8-hr. duty (day, evening or night), 40-hr wk. Living accommodation available. Apply in writing to: The Personnel Office, Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

ONTARIO

Director of Nursing for a new 66-bed hospital in Georgetown, Ontario, to be opened on June 1, 1961. Preference will be given to an applicant holding a degree in nursing supported by practical experience in a General Hospital. Duties to commence March 1, 1961. Please reply giving full particulars, including salary expected, to: Georgetown & District Memorial Hospital, Georgetown, Ontario.

Registered Nurses — starting salary $295 monthly, annual increments $10 per mo. to a maximum of $340, 28 days vacation after 1 year, room & board available in nurses' residence $45 monthly. Travel expenses refunded after 6-mo. employment. Apply: Director of Nursing, General Hospital, Atikokan, Ontario.

QUEBEC

General Duty Registered Nurses will be required in order to open two new wards at the Montreal Children's Hospital in January 1961. Good personnel policies & orientation program. Salary allowance for experience & postgraduate courses. Apply: Director of Nursing, Montreal Children's Hospital, 2300 Tupper Street, Montreal 25, Quebec.

ENGLAND

Plastic Surgery, Jaw Injuries & Burns Centre, St. Lawrence Hospital, Chepstow, Mon. England. (127-Plastic Surgery, 50-Orthopedic beds). 6-mo. postgraduate course on Plastic Surgery for Canadian trained nurses commences April 1st. Post provides opportunity of gaining further experience & seeing something of England. Full national Staff Nurses' salary paid (£498 a year, less £180 for board residence). Good knowledge of English essential & must pay own fare to England. This post provides an opportunity for those who wish to take a working holiday with pay. Write quoting 2 references to T. A. Jones, Group Secretary, 64 Cardiff Road, Newport, Mon. England.

REGISTERED NURSES — CERTIFIED NURSING ASSISTANTS

Modern 200-bed General Hospital with new wing under construction; located in the Garden City of Canada adjacent to American Cities and close to Toronto and Hamilton.

Good salary, 40 hour week with half-yearly increments — participation in payment of hospitalization, pension, and group life insurance — three weeks' vacation and statutory holidays. Copy of personnel policy available on request.

Apply:

DIRECTOR OF NURSING,
HOTEL DIEU HOSPITAL, ST. CATHARINES, ONTARIO.

DIRECTOR OF NURSING

Director of Nursing wanted. Modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan and direct education of (300 Student Nurses) and service programs. Perquisites include suite with service, pension plan, four (4) weeks vacation, sick benefits. Salary $7,000 - $9,000 annually depending upon qualifications and experience. Duties to commence as soon as possible.

Address replies to:

CHAIRMAN, CALGARY HOSPITALS BOARD,
CALGARY GENERAL HOSPITAL, CALGARY, ALBERTA.

CITY OF BELLEVILLE — HEALTH DEPARTMENT

SUPERVISOR *required for Generalized Program*

Blue Cross 50% paid by City — Pension, Group Insurance and cumulative sick leave available. Four (4) weeks vacation.

Car provided if required or car allowance.

Salary — $4,500 - $5,500 — depending upon qualifications and experience, annual increments.

Apply to:

MEDICAL OFFICER OF HEALTH,
266 PINNACLE STREET, BELLEVILLE, ONTARIO.

NURSING CONSULTANT (HOSPITAL INSURANCE)

required by
Department of National Health and Welfare, Ottawa
$7,500 - $8,700

Duties will involve advising on nursing services as related to hospital services in Canada, acting as consultant to provincial health and hospital insurance authorities on nursing aspects related to hospital services within the provinces and developing plans and techniques for the improvement of nursing services in hospitals.
Candidates must possess a **Baccalaureate Degree in Nursing**, registration in a province of Canada, at least ten years of acceptable experience, some in positions of leadership, and a broad knowledge of nursing in Canadian Hospitals.

For details write to
CIVIL SERVICE COMMISSION, OTTAWA.
Please ask for Information Circular 60-897.

THE NATIONAL HOSPITAL

Queen Square, London, W.C.1., England

(MEDICAL NEUROLOGY AND BRAIN SURGERY)

ADVANCED NURSING EDUCATION

One year courses are open to graduates of accredited Schools of Nursing having good educational background.

Three months academical teaching in the School of Nursing under guidance of Sister Tutor assisted by large teaching Staff of Senior Neurologists and Neuro-Surgeons.

Eight months Clinical experience, one month vacation.

Certificate and badge of the hospital awarded to successful students. Full graduate salary paid throughout the year. This work has a special appeal to nurses interested in research and the humanitarian aspect of Nursing.

Apply to:

MATRON FOR FURTHER PARTICULARS.

BURLINGTON, ONTARIO

REGISTERED NURSES

and

CERTIFIED NURSING ASSISTANTS

are needed for

a new 225 bed hospital

to be opened

February 1961

For information, write to:

DIRECTOR OF NURSING
JOSEPH BRANT MEMORIAL HOSPITAL
1240 NORTH SHORE BLVD.,
BURLINGTON, ONTARIO

GUELPH GENERAL HOSPITAL

Active — 200 beds — Fully Accredited

Requires

GENERAL STAFF NURSES

Pleasant city of 38,000 close to larger centers

Excellent salary and personnel policies

For further details apply to:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
GUELPH, ONTARIO.

McKELLAR GENERAL HOSPITAL

School of Nursing

will have openings for

INSTRUCTORS

in Medicine, Surgery and Pediatrics

by July 15th, 1961

Qualified applicants are invited to apply:

Salary commensurate with experience and qualifications.

Apply to:

DIRECTOR,
McKELLAR GENERAL HOSPITAL,
FORT WILLIAM, ONTARIO.

DIRECTOR OF NURSING

POSITION OPEN

111-BED MODERN HOSPITAL IN GROWING COMMUNITY ON VANCOUVER ISLAND.

APPLY WITH RECORD OF EXPERIENCE, TRAINING AND REFERENCES TO:

H. E. TAYLOR, ADMINISTRATOR,
WEST COAST GENERAL HOSPITAL, PORT ALBERNI, BRITISH COLUMBIA.

EDUCATIONAL DIRECTOR

FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

THE SCHOOL OF NURSING, METROPOLITAN GENERAL HOSPITAL

REQUIRES

INSTRUCTOR IN PEDIATRIC NURSING

This is an opportunity to be a member of the faculty in a progressive school which emphasizes educational experiences for the student in a program pattern of two years of nursing education followed by one year internship. One class of 30 students is admitted yearly. Duties include clinical and classroom instruction.

Requirements: University preparation in Nursing Education

Salary differential for degree.

For further information apply to:

DIRECTOR, SCHOOL OF NURSING, 2240 KILDARE RD., WINDSOR, ONT.

GENERAL DUTY NURSES (2)

FOR A MODERN, NEW 25-BED HOSPITAL

3 doctors on staff. 9 Registered Nurses, 3 Nursing Assistants, 1 Laboratory Technician, 1 X-Ray Technician. 5 day 40-hour week. No split shifts, 3 weeks vacation after one year service, 9 statutory holidays. Salary $280-$380. Single rooms in modern nurses' residence with television. Board and room $1.15 per day, laundry free. Established personnel policies. Apply in writing to:

JANIE SUTHERLAND, SUPERINTENDENT OF NURSES,
UNION HOSPITAL, P.O. BOX 760, ESTON, SASKATCHEWAN.

School of Nursing University of Ottawa

ADVISER TO SCHOOLS OF NURSING

The Saskatchewan Registered Nurses' Association

invites applications for the position of

ADVISER TO SCHOOLS OF NURSING

Applicants must possess a degree in nursing and have a minimum of five years experience in nursing education and nursing service of which the major portion has been in nursing education.

Apply in writing stating qualifications, experience and salary expected to:

MISS LOUISE MINER,
PRESIDENT, S.R.N.A.
5 BARTLEMAN APT.,
REGINA, SASKATCHEWAN.

A job description is available

KINGSTON GENERAL HOSPITAL

invites applications for position of

DIRECTOR OF NURSING

The hospital is situated in the cultural and historic city of Kingston. The new Connell Wing recently opened increased bed capacity to 625. A modern, new cafeteria, with a nurses' training school completes a brief picture of this fully accredited General Hospital. Salary is dependent upon qualifications and experience. Excellent personnel policies with 4 weeks annual vacation, pension and medical plans.

For further information address inquiries to:

SUPERINTENDENT
KINGSTON GENERAL HOSPITAL
KINGSTON, ONTARIO

HAMILTON GENERAL HOSPITALS

Invite applications from Graduate Nurses for the position of

CLINICAL INSTRUCTOR

at the Mount Hamilton Hospital to take charge of postgraduate program in OBSTETRICAL NURSING. Applicant must have at least one year postgraduate study at recognized university. Good personnel policies. Salary acording to qualifications and experience. Applications to be forwarded to:

SUPERINTENDENT OF NURSING,
MOUNT HAMILTON HOSPITAL,
CONCESSION STREET,
HAMILTON, ONTARIO.

VICTORIA HOSPITAL
LONDON, ONTARIO

Modern 900-bed hospital

requires

Registered Nurses for all services

and

Certified Nursing Assistants

40 hour week - pension plan - good salaries and personnel policies.

Apply:

DIRECTOR OF NURSING
VICTORIA HOSPITAL
LONDON, ONTARIO.

JEWISH GENERAL HOSPITAL
MONTREAL, QUEBEC

Completion of expansion program makes available attractive positions for Registered Nurses for Administration and General Duty and also for Certified Nursing Assistants. Instructor with post-basic preparation in Nursing Education required for School of Nursing. Excellent personnel policies. Salary in accordance with The Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education.

For further information, please write:

DIRECTOR OF NURSING, JEWISH GENERAL HOSPITAL
3755 COTE ST. CATHERINE ROAD, MONTREAL, QUEBEC

GENERAL DUTY NURSES

$335 per month, annual increment $10 monthly. 40-hour week, paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, Social Security.

Scholarship aid available for continued collegiate study.

Apply: Superintendent

ALEX. E. NORTON
NEW ROCHELLE HOSPITAL, NEW ROCHELLE, NEW YORK

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

CLINICAL INSTRUCTOR
FOR OPERATING ROOM

NEW ROCHELLE HOSPITAL
NEW ROCHELLE, NEW YORK

•

B.S. DEGREE REQUIRED

•

Salary depending on experience

APPLY TO: OPERATING ROOM SUPERVISOR

NOTRE DAME HOSPITAL OF MONTREAL

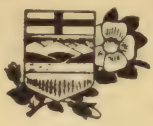
NURSES NEEDED

Salary, according to qualifications: $57.00 - $90.00 per week.
Evening differential: $7.00 per week. — Night differential: $5.00 per week.
Increases: After 6 months, 1 year, 2 years.
Free: Two meals daily — Laundering of uniforms.
Statutory holidays - 10 days; Paid sick time - 2 weeks (after 1 year)
Paid vacation: 3 weeks after 1 year, Pension plan.
Opportunities for promotion — Inservice education program.

For further information, write to:

LA DIRECTRICE DU NURSING — HOPITAL NOTRE-DAME — MONTREAL

PROVINCE OF ALBERTA



EMPLOYMENT OPPORTUNITY

GENERAL DUTY NURSES

Salary - $3,480. to $4,080. per annum. 40-hour week, Civil Service holiday, sick leave and pension programs.

DEPARTMENT OF PUBLIC HEALTH
Baker Memorial Sanatorium
Calgary, Alberta

Apply, giving full details, to the Baker Memorial Sanatorium, Calgary, Alberta.

OTTAWA CIVIC HOSPITAL

requires

GENERAL STAFF NURSES

for

OPERATING ROOM
MEDICAL
SURGICAL & OBSTETRICAL } DEPARTMENTS

Apply

EDITH G. YOUNG, REG.N.,
ASSISTANT ADMINISTRATOR - NURSING

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

GENERAL DUTY NURSES

WANTED

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THE CANADIAN NURSE

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1960

The material in this Index is arranged under subjects, authors and titles. Titles are given in full with the author's name.

The following abbreviations appear in this Index:

CNA — Canadian Nurses' Association
(ed.) — editorial
I.C.N. — International Council of Nurses
(por.) — photograph
U.N.B. — University of New Brunswick
WHO — World Health Organization

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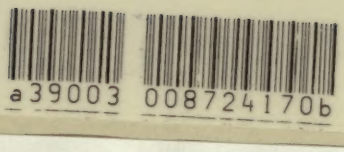
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